The Public Health Nurse

Volume XXI June, 1929 Number 6

Preschool Number

Posture Classes
The Unadjusted Child
Prevention of Heart Disease
Diphtheria
Medical Examinations

Future Service to N. O. P. H. N. Members

The PUBLIC HEALTH NURSE

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FUTURE SERVICE TO OUR MEMBERS

ON April 19th and 20th, the Executive Committee of the N.O.P.H.N. had a meeting of so much interest and stimulation that we want to share its thinking with the membership. A sub-committee, composed of Mary S. Gardner, Sophie C. Nelson and Florence M. Patterson, on Program and Policies of the N.O.P.H.N. met previously with the General Director, to review the place of the whole organization in the health field—its present trends and future possibilities. The discussion of the Executive Committee was based on the report and recommendations of this sub-committee.

The report of the sub-committee began with the following declaration:

> We believe that there is need for a permanent body such as the N.O.P.H.N. which shall be conducted as a definite entity. Its special province shall be the use of the public health nurse and her relation to public health and social programs. For the present, the N.O.P.H.N. will continue to function in three ways: service to its individual and corporate members; the development of a sound relationship with other national bodies in such a way that increasingly the use of the public health nurse in, and her relationship to the various phases of the public health and social program may become greater and more effective; and the development and carrying out of special studies, surveys and research projects. Undoubtedly there will and should be more emphasis on the latter two parts of the program after other decentralized groups are developed to handle the service phase adequately.

It was felt that the service of the N.O.P.H.N. to its individual and corporate members could be further extended through more use by the membership and greater emphasis by the national office. Such services fall into the following groupings:

SERVICES TO MEMBERS

A central bureau of information—based on material gathered through the N.O.P.H.N. Statistical Department, covering such subjects of general interest as salaries, census of public health nurses and organizations, etc.,

and on material covering general and local practices in the various aspects of public health nursing activities, such as the hourly and delivery services, publicity methods, etc.

Special studies—like the study of the Committee to Study Visiting Nursing, the study of staff education and student affiliation, studies and advice as to records and statistics, and the publishing of the nursing manual all are a very direct service to the membership and through constant review and reconsideration give not only the best of current practice but should point the way to next steps in effective administration of public health nursing services.

Advisory Service—Closely allied to the above activities is the advisory service through correspondence, office conferences and field service. The Executive Committee and the staff are eager to extend the organization's activities in the field. This, of course, is the most expensive phase of the advisory service, but correspondingly, probably the most satisfactory. While it is desirable insofar as possible that local agencies bear part or all of the cost, the N.O.P.H.N.—true to one of our most fundamental public health nursing principles—wishes to give this same field service to communities that can pay only part or nothing. The extent to which this free or part-pay service can be given must be conditioned by two considerations—the need for the service, and the budget of the N.O.P.H.N.

Basis of payment for field service—Insofar as possible it is desirable to have traveling and living expenses for the N.O.P.H.N. staff paid for by the organization or groups served. For special field consultation of more than one day or for special studies, a per diem charge in addition to traveling and living expenses is being worked out that will cover the actual cost to the National Organization. It has been found that this is the policy of other national agencies offering similar services to their constituency in their particular field. However, the Executive Committee lays emphasis on the possibility of individual adjustments based on the nature of the situation and the ability of the budget of the N.O.P.H.N. to meet the special need.

Furthermore, the Committee reached a very important decision as to those organizations that are on the Percentage Plan, as follows:

> That those organizations which are on the percentage plan will be given a credit of 25 per cent on their percentage which they are paying, toward the services of the N.O.P.H.N. for which a charge is usually made.

Other services—Other important and well-known services of the N.O.P.H.N. are its Vocational Service through the Joint Vocational Service, Inc., its magazine, THE PUBLIC HEALTH NURSE, and its library service, through the National Health Council Library.

Promotion of standards—Last, but by no means least, is the place that the Organization takes in the promotion of standards through its studies and research, its activities in the field of public health nursing education, and the medium it offers for pooling of experience, the development of group thinking and making possible group action.

Relatively undeveloped opportunities.—The Executive Committee recognized that there were certain fields in which the N.O.P.H.N. should be much more active: the school nursing, industrial nursing, the extension of public health nursing for the negroes by their own nurses.

RELATIONSHIP TO OTHER NATIONAL NURSING BODIES

American Nurses' Association—Conceiving of the American Nurses' Association as the professional body of and for nurses, eventually and as rapidly as possible the distinctly professional aspects of the N.O.P.H.N. program should be turned over to the American Nurses' Association. This would mean that questions or actions that are of concern to public health nurses primarily as nurses, would be

considered as part of the function of the A.N.A. It was felt that every effort should be made to strengthen the position of the American Nurses' Association as the professional organization for all nurses, in which public health nurses as individuals take an active part, contributing to the professional group as a whole out of their special experience. The N.O.P.H.N. would not be considered primarily a professional organization but as concerned with community services and the part that public health nurses and public health nursing organizations may and should play in such services. It is worth considering whether such a clarifying conception and definition of the relationship and functions of these two organizations might indicate that the time had come to think of changing the by-laws of the N.O.P.H.N., so that any officer could be chosen from the whole membership—nurse or non-nurse.

National League of Nursing Education—As this body is concerned with nursing education the question arises whether all phases of the problem of education of nurses—postgraduate as well as undergraduate—should be pooled in this organization. If this should seem the proper allocation of responsibility, to what extent could and should the educational program of the N.O.P.H.N., so far as it relates to student affiliation and postgraduate courses in public health nursing, be placed in the hands of a committee of the National League of Nursing Education, made up as is the present N.O.P.H.N. Education Committee of course directors, administrators of public health nursing organizations, educators, the lay public, and those concerned with schools of nursing? The Executive Committee felt that such a possible division of responsibility needed time for the most careful consideration by both national bodies and certainly would involve many practical problems, such as an equitable financial adjustment.

As staff education programs relate to the administration and conduct of public health nursing services, these would naturally remain as part of the concern of the N.O.P.H.N.

RELATION TO OTHER NATIONAL AGENCIES

One of the important opportunities of the N.O.P.H.N. is the possibility of extending its working relation with other national health and social agencies, the ultimate object of which would be to develop the most effective ways of using and relating the public health nurse to the various phases of public health and social program. Through the National Health Council, the National Social Work Council, and joint committees, mutual coöperation and understanding can be greatly furthered. It is hoped that the N.O.P.H.N. may also be of especial assistance in developing the programs of the national health agencies insofar as these touch public health nursing.

Joint project with the American Social Hygiene Association—The part that public health nursing may play in social hygiene programs is as yet a more or less undeveloped field—nevertheless, public health nurses have an exceptional opportunity to make a real contribution. Therefore, a public health nurse is to be added to the N.O.P.H.N. staff to study these possibilities and assist in the further incorporation of social hygiene into local public health nursing programs. This project is to be jointly financed by the American Social Hygiene Association and the N.O.P.H.N. and will be carried out with the assistance of a joint committee through the two organizations.

SPECIAL STUDIES AND RESEARCH

This is a day of emphasis on relationships in all phases of human life and endeavor. We do not, and can not live unto ourselves alone, nor can we work effectively out of relation to others. The Executive Committee realizes the need for further study and understanding of the relationship of public health nursing programs to

many other closely allied groups and programs; the relation of public health nursing to social programs and social workers; to mental hygiene programs; to hospital and hospital social workers; to official and non-official agencies. It is the desire of the Executive Committee that the N.O.P.H.N., through working more closely with other national groups concerned, may further the development of more complete understanding and more productive results in connection with these many problems of relationship.

In the outline of the services offered to the membership and the organization's relationship to other national bodies as stated above, there is evidenced the need for further study and research along many lines. It is the desire of the Executive Committee that this phase of the N.O.P.H.N. activities may increase and make a continually greater contribution to the whole field of health work.

A NEW SECTION SECRETARY

Board and Committee Members Section — The Executive Committee considered most favorably the very strong recommendation from this section that an addition be made to the staff of the N.O.P.H.N. of a person who could act as adviser to boards and committees and be secretary to this section. Such a person would be one familiar with the activities of boards and not a nurse. It is hoped that it will be possible to take this action by allocation of a special fund but no definite announcement can be made at this time.

FUTURE QUESTIONS

Decentralization — The importance of decentralizing as rapidly as possible some of the activities of the N.O.P.H.N. is recognized. It is realized that the logical place for much of the advisory service is the public health nursing division of state departments of health. How can N.O.P.H.N. assist in strengthening the state service so that it may increasingly meet a larger part of the local need?

State Branches—How effective are our state branches? Is this a cumbersome form of organization that is satisfactory in relatively few states? Would state conferences on public health nursing, similar to state conference on social work, with no restrictions as to membership, more nearly and simply meet the actual situation? Would some form of state regional councils on public health nursing—including the state commissioner of health, the state public health nursing supervisor, representation from the state board of education and the state department of public welfare, directors of post-graduate courses within the state, and representation from the lay public and public health nurses engaged in carrying on public health nursing services—serve the purpose of a continuing representative group and be more effective in developing public health nursing throughout each state than the present state branches?

Sections—With the exception of the new Board and Committee Members Section, are sections on special phases of public health nursing sufficiently productive in their present form to make continuation desirable? Would advisory committees along these special lines with geographically representative membership meet the need more satisfactorily and with a less complicated machinery?

These are some of the questions about which the Executive Committee is thinking and recommending the consideration of the membership throughout the country.

Final decisions were not made at this meeting, except as to the credit to be given to corporate members on the Percentage Plan and the joint project with the American Social Hygiene Association. The thinking and action of the membership is needed before many of the ideas can or should be put into effect. The relationship to the American Nurses' Association and National League of Nursing Education and other national agencies requires mutual thought and action.

This is but a preliminary statement so that our membership will share the questions, hopes, and responsibility for action with the Executive Committee and staff.

FINANCES

A word about the financial status of the Organization which certainly should have a place in any consideration of program or activities. The Finance Committee and Executive Committee find the financial situation sound. It is the determination of all to adopt a program of activities whereby the budget for expense will equal and not exceed the budget for income. The most stabilizing factor in the whole financial situation is the Percentage Plan. It is hoped that as the more tangible services of the N.O.P.H.N. increase, the income from the percentage contribution from agencies will grow accordingly. Certainly other similar national organizations have found this to be the only sound basis of financing. Therefore the N.O.P.H.N. is not acting on a theory but on a practice tried and proved.

In closing this report of the two days meeting of the Executive Committee, it cannot be emphasized too strongly that the Committee and staff feel the need of active participation of the membership in all that concerns the organization—its program and policies. The major consideration is how your National Organization can best assist in making it possible for public health nursing to take its proper place in local, state and national health programs.

KATHARINE TUCKER
General Director

I. Malinde Havey, Director, American Red Cross Public Health Nursing Service, Washington Branch, has accepted the chairmanship of the N.O.P.H.N. Nominating Committee for officers for the next Biennial period. Owing to frequent absences from the city, Miss Kraker, the former chairman, has had to resign. The committee includes: Naomi Deutsch, Theresa Kraker, Mrs. Elsbeth Vaughan, Mrs. Kathryn Schulken. A list of vacancies to be filled at the Biennial Convention in Milwaukee in 1930 will be found on page 215 of the April magazine. Suggestions will be welcomed. Please send them to Miss Havey, American Red Cross, Washington, D. C.

Posture Classes for Preschool Children

By Rosamond Praeger
Supervisor of Child Welfare Nursing, Department of Health, Syracuse, N. Y.

THE first service of a preschool posture class, as its name implies, is to meet the needs of the individual child in the specialized field of posture. His needs are measured by the posture examination, and steps taken to meet them by exercises, assigned from time to time, according to his age, his problems, and his progress.

Since this is a highly specialized service, one of several offered in a preschool program, each child must first register in the clinic, where his history is taken and a complete physical examination made. In referring the child to posture class the close relation of posture to nutrition, fatigue, and mental alertness is recognized.

In the Syracuse posture work examinations are made, exercises assigned, and data checked by the department orthopedist. The clinic nurse is, of course, his active assistant, but her responsibilities are less specialized. She is concerned in seeing that all activities in the health center shall run smoothly and bear fruitful results. She is hostess and housekeeper. She is the constant factor at the health center. She knows, too, the child's home situation and attempts to improve and enrich it. She follows eagerly and hopefully the whole and continuous progress of each small member.

FROM BABY TO PRESCHOOL CLINIC

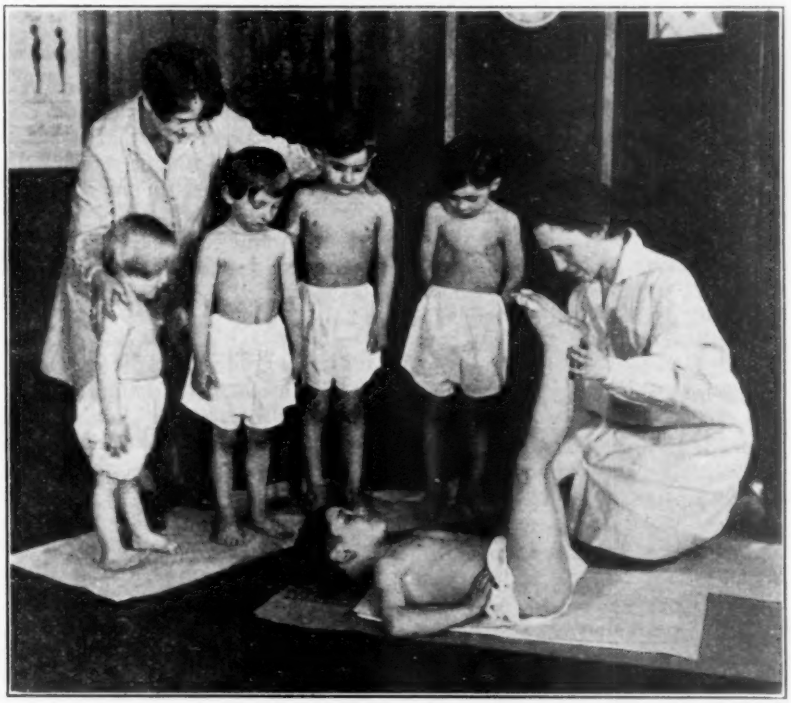
The child and mother, promoted from a baby clinic to a preschool clinic, suddenly find themselves scheduled to report at much less frequent intervals. The physical examinations may now be several months apart, and to preserve the continuous record of the child more frequent visits to the center are necessary. Weight must be taken, home hygiene and nutrition discussed, and habit formation guided. The various classes held at the center afford opportunity for this supervision, and preserve the habit of coming to the center. It becomes a part of the family routine.

There is so much that we must transmit to our clinic mothers in theoretical form, that something active on the part of mother and child, which can be clearly described and demonstrated, as posture exercises, often affords an ideal vehicle. The whole hygienic program of rest, nutrition, recreation, cleanliness, follows hard upon it. Attendance records, too, may be seen. Stars on a chart appeal to children and parents.

From the angle of administration of nursing time these visits of the mother and child to the center for a weekly check-up are a great economy. When the nurse has been in the home enough to secure an adequate picture of the child's background, and the situation does not demand her presence there for some special service, it is efficient practice for her to interview a number of mothers in her own office in the time that it would require to make one or two home visits. There is sound psychology in requiring this effort on the part of the mothers.

THE FRIENDLY CLINIC

The friendly clinic draws the child, and the child brings the mother. Kindergarten furniture, suitable toys, pictures, bright oil-cloth on the tables, an atmosphere of cordiality and interesting activity all contribute. Toys must be selected thoughtfully. They must be suited to the ages between two and six years. They must challenge the attention for a short span of time, just long enough to afford real interest and pleasure, not so interesting that the child must be torn away, perhaps amid tears, to do his exercises or take his departure. They must be quiet toys, thoroughly good in quality, and



Posture is a Stunt in Syracuse

in the lessons which they teach. Wooden beads, wooden blocks, nests of blocks, blunt scissors and bright papers, pictures to be cut, pictures in books not to be cut, crayons, slates, and many others are useful here. Sometimes a picture particularly well colored or cut may be taken home to father along with the record of weight or other clinic report. All forms of achievement are given their due recognition.

Sometimes the toys serve a very definite purpose, as in the case of Betty Anne, who, though only three was acutely conscious of her position at the tail of the class in posture, but who could build block towers that were admired by all. Thereafter Betty Anne, having once enjoyed adulation, had a taste for more, and her posture progress increased accordingly.

The play spirit is not checked with the beginning of examinations and exercises, and the work benefits thereby, for a little child is most wholehearted in his interest when at play. The exercises are fun, we sometimes call them "stunts." Some have interesting names as "the bridge" and "the dog walk." The play before the posture work affords a change of interest and activity, relieving fatigue, which might defeat the purpose of the exercises. How much composure and happiness contribute to the actual posture work we cannot measure, but certainly habits initiated and rehearsed with a real feeling of joy are much better rooted.

POWER OF IMITATION

The new member has opportunity to observe how things are done and the uses to which the strange, though few, pieces of apparatus are put. When a little sister watches her big sister, already initiated, step carefully on the scales, she is eager to follow. Through the example of others in the class, fears and undue modesty or shame are discarded. A wholesome

desire to measure up in matters of health is substituted.

Recognizing that small children learn most through imitation, the very little ones go through the program of the posture class but are given the simplest exercises and not forced beyond the span of their enthusiasm. Through watching the older children, verbal instructions put on meaning for the small ones. If the two-year-old learns the simplest coördinations, how to take commands, and some measure of self-control, he has gained much. He learns, too, the names of the parts of his body, the meaning of "right" and "left." Imitation also helps him learn initiative, to attempt to dress and undress himself, to put his clothes in their proper place, and many other practices which are the fashion at the health center. On the principle that as the twig is bent so the tree inclines, we count the time given to these littlest people as well spent.

Mothers and children alike gain knowledge by experience here of the proper protection of themselves and others from any possible contagion. Health facts, health vocabulary, health attitudes are the order of the day, and in a form that is easily transplanted into the life outside of the clinic. The weekly repetition of this program is a strong factor in making it habitual. This periodicity can only be accomplished by a class with a definite function.

USE OF POSTERS

Posters aid in emphasizing health facts and teaching new health words, but time should be taken to discuss the story which the poster tells. To the busy nurses, who frequently cannot make time to renew the poster display as often as their ambition dictates, it is comforting to realize that little children love repetition of their favorite themes. They are drawn by what is familiar. Good posters, placed low, so that very little people may come very close, may remain on the walls for many weeks, and the story be repeated an endless number of times. Posters with positive suggestion are better for children of this age than pictures of things as they ought *not* to be.

Since a general scrubbing up of the child and his clothes usually precedes a visit to the center, actual cleanliness is not only taught but rehearsed. Improvement in health practices at home and correction of any defect receive attention and commendation. Encouragement from week to week increases this effort to meet the expectations of friends.

MENTAL ATTITUDES

The practices of mental health have their weekly rehearsal, and in this, too, mothers have a practical demonstration of how certain situations may be handled. The child is expected to measure up to his full powers. In the health center no one babies him, he is waited upon no more than is absolutely necessary. The only child finds himself one of several, receiving his share of attention, but no more. The difficult child finds that he creates no particular stir by his unfriendly conduct, in fact is rather ignored, but soon discovers that friendly ways and real effort in the right direction bring the attention he so much wants. Everyone learns to take his turn, to do his part in teamplay, to share in the spirit of the game. The older children have plenty of opportunity for wholesome competition. Initiative, self-help, perseverence are expected to the degree appropriate to each child's age and experience.

Pleasant friendships are formed in the posture class. The nurse, already a familiar figure in the homes of the children, is the first to greet the newcomer to the class. Lasting friendships are formed, too, among neighbors. One group of children from the posture class assembled daily for a whole summer on a neighborhood lawn, to practice their exercises together in the sunshine.

COMMUNITY RELATIONSHIPS

The horizon of mother and child is broadened to include other community relations. We are fortunate in the Syracuse Preschool Clinics in having

as volunteer workers students from the Vocational High School and the kindergarten department of the City Normal School. The same "teachers" come for a long enough period to become well acquainted with their small charges. They bring new enthusiasm and helpful ideas to the play life of the clinic, and take away a better rounded knowledge, an understanding of the physical well-being of the child they expect some day to teach.

A relationship, both professional and friendly, is established between the child and the physician. Any associations of pain or illness which a child may have had in the past with his physician, tend to be erased by the repeated friendly contacts in posture class. Here they have fun together, real companionship for an hour or so.

The posture class means, then, that for at least an hour during each week, these children whom we are striving to help are brought together in an environment which is controlled, where physical and mental well-being are the paramount consideration. They learn that there is happiness in health and in health achievements, and find through this common aim many pleasant hours and gratifying friendships.

CANDY AND SUGAR

Courtesy of
"Maternity and Child Welfare"

That the eating of candy easily lends itself to abuse is a fact which until recently was clearly recognized by nearly everyone. Even those who indulged freely in sweets agreed that it was an indulgence and not an entirely wholesome food habit. But at present there seems to be on foot a concerted attempt to obscure this fact. And not only is the public being "educated" to eat more sweets, but some writers, who undoubtedly have ability and influence, are advocating the feeding of more sweets to children. Are their arguments sound?

Careful study of much that has recently been written in behalf of increased use of such concentrated sweets as candy leaves me with the distinct conviction that such teaching is not sound from the standpoint of the health interests of children. In my judgment, it is just as true today as it has been for several years past, that the practical lesson to be learned from the newer knowledge of nutrition is the great importance to health of giving a more prominent place, in our eating habits, to "the protective foods," *i.e.*, milk, fruit, and some of the vegetables; and that a "more tolerant" attitude towards sweets for children is not justified except in so far as the use of sugar may be practically helpful in preserving the protective foods or facilitating their attractive preparation.

A moderate amount of jam may be good for children—its sweetness may appeal to their palates and its fruit content will almost certainly be good for their health. A liberal amount of ice cream may be good—they may like it because of its sweetness and they will almost certainly be benefited by the extra milk and cream which they thus get. Without multiplying illustrations, it may be said that in general the proper place of sugar in the food supplies and eating habits of children is not in such concentrated forms as candy, nor in the indiscriminate and excessive sweetening of all kinds of foods, but rather as a preservative and flavor to facilitate the introduction into the child's dietary of larger amounts of the fruit and the milk, the importance of which to child health has been increasingly emphasized with each year's progress in our knowledge of nutrition.—*Child Health Bulletin, May, 1929—Reprints of complete article from American Child Health Association, 370 Seventh Avenue, New York City, price 4 cents.*

The Nurse's Place in the Field of Child Study

By Winifred Rand, R.N.
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THE nurse's place in the field of child study is to join it! Surely every nurse who is to have anything to do with children and that must, of course, mean every public health nurse, needs to know about children and knowledge about children is not a knowledge that just wafts itself over us like a summer breeze. To know about children means that one must *study* about children. Let us face that fact without any equivocation. The time was when there was no chair of pediatrics in medical schools, the time was when courses in psychology began with a study of the adult mind and the child was ignored. But that time is no longer. The child is worth study, in fact the child is all important as a subject of study. To understand life in all its facets one must understand children, their needs, their growth physically, mentally, socially and emotionally, their actions and reactions. The child is the Alpha from which one progresses to the Omega of life. The end has in its roots the promise of its destiny. The final results are understood in the light of the beginnings.

BOTH OLD AND NEW

One somewhat complacently thinks that an awareness of the importance of childhood and a knowledge of children is a modern awakening and yet "As the twig is bent so is the tree inclined" is not a modern saying, and over three hundred years ago Comenius, a pastor in Moravia, wrote a guide for mothers called "The School of Infancy" which says many of the same things which we are saying today. Not so modern, after all, the emphasis on the importance of the early years but modern perhaps, the more universal acceptance of the fact and the application of scientific principles to the study of the child. Modern, therefore, the institutes for child welfare research, centers for teaching and research established in order that more may be known about the child and more taught about the child.

The nursery school, an English venture in education accepted by the Fisher Act of 1918 as part of their educational system, has been to a great extent developed in this country in conjunction with the various child development research centers—particularly well fitted to perform a necessary three fold function. A laboratory where research in the various aspects of child development may be carried on, a laboratory where those who need to know (and who does not, parent or pre-parent?) may have guided observation and experience with growing, learning children, it must preeminently be a place *for* children, where they may indeed be free to grow physically, mentally and socially. Unless we know what a child *may* be how can we set standards as to what he *should* be?

THE PLACE OF THE NURSE

To seek knowledge, to give information, to offer the fullest opportunity to children, where in an institution carrying out such a program should we find the nurse? In the field of seeking knowledge about children there is of course, research to be done as to the child's physical life and needs. Nurses, however, are not primarily trained to carry on or direct research work although as pupils in a child development center they would probably be particularly interested in undertaking some study along the line of the physical needs of the child. The child's sleep requirement, the incidence of colds, for example, are both subjects which would naturally interest a nurse who was doing some studying at a child research center.

In the field of giving information

about children, the nurse, especially if she has had training in a children's hospital, has a task to perform for she has been taught something of the physical care of children which probably no other member of the staff has been taught. She knows certain techniques for physically handling children and giving general care that the psychologist, the nursery school teacher, the nutritionist and even the doctor may not have been taught—but her knowledge does not in reality cover a wide field. Her knowledge of nutrition is too limited in comparison to the knowledge of nutritionists to fit her for teaching this subject particularly as it relates to normal children, nor is her knowledge of growth and the factors affecting it sufficient without further study for her to teach a course in physical growth and development. She will probably assist in giving such a course but she cannot give it all.

THE NURSE IN THE NURSERY SCHOOL

In the nursery school, that place where children are to be given their fullest opportunity for optimum development, the nurse has a daily part to play. Each morning children must be inspected before entering the school in order that the group may be protected against the possible spread of contagion, and for such a task the nurse is particularly fitted. At stated intervals the children will be given complete physical examinations at which times the physicians may like the assistance of the nurse. One may, however, find the nutritionist serving as this assistant—for in a study of normal growth the nutritionist is as interested and as well prepared to carry on as the one whose first concern has been the care of the sick. The nurse too is a most comfortable person to have on hand to meet the physical exigencies of the day. Bumps and bruises, cuts and other emergencies which will "sometimes occur even in the best regulated" nursery schools are attended to by her with a wisdom and poise which is not acquired so easily by one whose background is far removed from pain and hospital wards. The nurse on the staff is the one who should be particularly sensitive to the ventilation and the temperature of the room, the signs of fatigue in the child, the first symptoms of physical disturbance, the need for rubbers and leggins, or any other signs of physical need which her training has taught her to detect. But let us face the facts! In the daily regime in the nursery school the nurse merely as a nurse has really little to contribute although potentially she has much.

OPPORTUNITY IN THE FIELD OF CHILD STUDY

First, the field of child study has much to *give* the nurse especially if she is a public health nurse. The educational process begins with life itself and the nurse who can get that point of view—who can add to her knowledge of the physical care of the child a knowledge of a child's mental and social growth which will save her from giving the wrong advice or doing a harmful thing to the child—is a nurse who should be of inestimable value in any child health program. She will have a conception of the goal toward which she is working, and the techniques which will help in its attainment that the nurse without that experience cannot have. Let nurses, therefore, particularly public health nurses, turn toward the field of child study to round out their education and so prepare them for more adequately dealing with the child in whatever field of work they may enter.

A nurse who has thus completed or rather enriched her education—for when is education "completed"?—will find herself ready in turn to make her contribution as part of the child development center. A nurse's training may be a most satisfactory background for a nursery school teacher to have. One of the aims in nursery school work is to develop in the child the right attitude and understanding toward physical living and health habits, and the young woman who has combined a nurse's training and prepa-

ration for nursery school teaching has a knowledge at her command which should especially well fit her for carrying out this aim. She should have a respect for health and healthful living which the teacher *per se,* alas, too often does not have. Also she has the right attitude toward some of the routines of physical care for the very little children which again the teacher's training by itself does not necessarily give, and her nurse's training naturally gives her a sensitiveness toward physical needs.

A nurse, particularly a public health nurse, who has first entered the field of child study as a student may become a most satisfactory home visitor for a child development center. Her experience has fitted her to make contacts satisfactorily; as a nurse she usually finds an easy entrée and she has a knowledge of physical care which a social worker does not have.

In fact the child health nurse who in the field of public health nursing has been known as a specialist may find herself in the unique position of being a general worker in a field of highly trained specialists. In whatever capacity she may serve, as nursery school teacher, as assistant in the nursery school, as social worker, she will not serve merely as a nurse but as an individual, who because of an all round viewpoint about health in its various aspects may serve as an integrating force in the group of psychologists, teachers, nutritionists and physicians who together are concerned with the child's welfare. Therefore, although today the nurse as nurse needs the child development center more than the center needs her, she is nevertheless needed there and by rounding out her training she can come, bearing gifts which are her own peculiar gifts.

Hanging the Babies Out to "Sun"

From the Syracuse (N. Y.) Visiting Nurse Association comes this unique picture of babies being given a place in the sun at The Baby Home. Eighty-nine undernourished and convalescent babies were cared for in 1928. A training school for nurse maids is conducted in connection with the home, a twelve months' course being given.

A Day with the Nurse and Nutritionist in an Indiana County

By Clyde B. Schuman
National Director, Nutrition Service, American Red Cross
and
Esther Tress
Itinerant Red Cross Nutritionist

"READY?" inquires the nurse, bursting into the Red Cross office. "We need an early start today. The doctor phoned to put up a scarlet fever sign." "Yes," replied the nutritionist, "as soon as I get my hat."

Donning hats and coats, we check over our supplies for the day: scales—Red Cross tags—school bag—records—charts—posters. With "Don't forget the lunch," a run to the car, we are off to a consolidated school ten miles distant.

Turning in a lane after a half hour's ride, we stop at a farmhouse. While the nurse tacks up her scarlet fever sign, I correct papers, a supply of which I keep in the car for just such odd moments. We make every effort to make traveling around in the same car not a waste of time since it is the only way we can carry our work until the Red Cross Motor Corps is organized or a second car is possible.

CLASSES WITH THE GRADE CHILDREN

Arrived at the consolidated school, the nurse goes to her high school work while I go to my nutrition classes with the grade children.

The primary youngsters cut out milk bottles. These are taken home for mother to admire, then tacked up on the kitchen wall. Every time a child uses a cup of milk either in other foods or as a beverage, a cross is put on the bottle. Not long ago a mother whose child was keeping this record suggested he mark his bottle ahead as he always drank milk with his meals. "But Mother," said the scandalized child, "I can't do that. We only mark the bottle after we drink the milk." The primary children also mold carrots and spinach out of clay and take them home to show mother and father or invite the

Off to an early start

parents to come to school to see them "play" garden.

Nutrition is taught through relating it to geography and other subjects in all grades. In the intermediate grades we find the dairy states on an outline map of the United States. Our geographies tell us how other countries get their milk and something of how they use it so we can make comparisons with the way our country uses milk and produces it by states.

It is always a great treat to children in the upper grades to study the composition of a quart of milk. They view with some astonishment the bottles which the nutritionist holds up. One contains the sugar which we find in one quart of milk—so much sugar that no additional amount is needed on fruit or cereal—another contains the protein; the butter fat is in a third; the lime is in the fourth bottle. The chil-

dren then figure their supply of these through the milk they drink. They also figure their need of these.

THE ONE ROOM SCHOOL

Our next stop as we travel on is at a one-room school. At my class of teachers last week Miss Brown had asked for suggestions for her hot lunch and I had promised to bring her some pamphlets and recipes. We are welcomed royally by teachers and pupils. Up go the hands of the youngsters and in chorus, "We are going to have baked potatoes for lunch." Sure enough, on the flat top of the furnace-stove bake twenty odd potatoes, and on the window ledge we also find twenty odd bottles of milk. As I helped the teacher with the lunch the nurse looked over the water supply and the sanitary arrangements. As she comes in the school door she says, "Let's show our handkerchiefs, but do not shake them out." All but five can produce the article and so the nurse suggests that the teacher get a supply of paper handkerchiefs from her school trustee.

As we put on our wraps we note that desks are cleared and the pail of water warming on the stove is removed to the back of the room by the captain of the cleaning squad. By rows, the children file to the back, wash their hands and return with their lunch buckets or baskets. Paper napkins are passed to each child and the split potato is laid on each, while the children place the apples, milk and other food brought from home on their desks and begin to eat. They all insist on having twenty minutes for lunch.

Regretfully we leave for the next school on our schedule where we eat lunch of hot milk flavored with cocoa and sugar carried in a thermos bottle, peanut butter sandwich of whole wheat bread, two raw carrots and a piece of gingerbread. We are careful to expose our lunch to the children's view.

HIGH SCHOOL CLASSES

Lunch is over when the bell rings and the nurse continues her individual inspection of children from last week in one room while I teach nutrition in the other. At the high school class which follows, the students figure the number of calories from the record of the food they ate one day last week, and check themselves for their own information on their nutrition score sheet. They take these home and recheck a day or two later for their own information to see their progress in choosing food. The lesson for the next time is assigned, the group reweighed—teacher and children doing the weighing—and the weights plotted on their weight charts.

In the basement, a group of mothers is assembled. The problems of these mothers are varied—planning school lunches, fattening their children, reducing or increasing their husband's weight and working on their own through the food supply on their home table.

A home visit and the day's work is done. The case is a mother with tuberculosis. Her three children are very much underweight, so while the nurse is caring for the patient, I help the children, the oldest only twelve, to plan some adequate meals for both mother and the well members of the family.

WORKING WITH THE COUNTY NURSE

No diary of a day, or a four months' period, of the nutritionist in this county is complete without a word of appreciation of the county nurse. In her work over the county she had seen and recognized the need for education in nutrition and was prompted to put the problem before her Red Cross Chapter. The Chairman, who happened to be a former Superintendent of Schools, and the present Superintendent both understood and appreciated that their county needed education in nutrition as well as in other subjects. They reasoned that if the school children could receive graded instruction in nutrition and the parents and other adults could be reached in the homes and through clubs, the whole community would profit. Sufficient funds were available through roll call for the chapter to employ a nutritionist for only

four months, so an itinerant nutritionist was employed. Weekly classes with school children, talks to children, adults and various other groups and organizations, mothers' classes, teachers' classes, home visiting and consultations all had their part in the Red Cross nutrition program. Teachers are eager for information about nutrition and methods of teaching nutrition. As they put it, "It is of great personal help in the selecting of well balanced meals 365 days in the year."

FOOD PROBLEMS

In talking with mothers all over the country we find similar food problems existing. Father and Johnny may not like green vegetables. Little Mary won't drink milk. The high school age prefers a meal at the ice cream parlor of sundæs and sodas rather than a meal of vegetables, fruit and milk. "How can I get my family to eat the proper foods so I can bring up the weights of underweight children?" ask these mothers of the Red Cross nutritionist, whether working in Indiana or in other states. The nutritionist helps to make eating these needed foods popular. Sometimes an animal demonstration of the right and wrong diet is helpful to bring before the public the effect of the average American diet on young animals. In our county we, the school children and the nutritionist, fed our four rats, two a correct diet and two the kind of food—incorrect—which the children chose to test out. On all sides we heard the children saying, "My goodness, I didn't know food could make such a difference. I sure don't want to be like our skinny rats. I'm glad I am learning *how* to eat."

ITINERANT NUTRITION PROGRAM

The day we have described is from the diary of a nutritionist in a real county in Indiana. This county was the first in the state to put in a Red Cross nutritionist to work with the nurse, the physicians, the schools, the parents and the community at large in an effort to bring about improved nutrition. The chapter has carried the itinerant nutrition program for a four months' period for two consecutive years and plans to continue the program. The nutritionist has given regular graded instruction to 46 schools, 70 class rooms and an average of 1,696 pupils. A number of these were junior and senior high school students (not in home economics classes), but a definite effort was made to try to reach all the children in the elementary schools. A large percentage of the teachers took the Teachers' Red Cross Nutrition Course during the year 1928-29 and received university credit for it. During these two years mothers' classes were held throughout the county and many mothers now proudly exhibit their Red Cross certificates for the Food and Nutrition Course, and proudly tell you that they are now observing in their homes what they learned and that "it works."

The nutritionist also has conferences with mothers and others in this county, helping them with their individual problems, budgetary or relating to food preparation. In this county as in others problem nutrition cases related to tuberculosis, etc., are found. Even with the limited time possible for such cases in an itinerant program the nutritionist has been able at the request of the physician in charge to visit a number of homes and later to give advice through conferences at the office to these problem cases. The nurse and the nutritionist work from the same office and plan their schedule carefully together so as to put up the "scarlet fever sign" and do the day's nutrition work without loss in time for either. Since this first program was started four more Red Cross chapter nutrition programs have been started in the state with itinerant nutritionists. One or two of these are now on the way to becoming full time programs. No program started has been discontinued.

STRESS ON THE GREATEST NEED

Whenever Red Cross nutrition work is developed each community, through its nutritionist, or nutritionists, undertakes to give to those living in the community the phase of the nutrition

program which is most needed and best adapted to its particular need. In some chapters the prenatal and preschool program is developed in advance of the school program. In others the school program comes first. The preschool work embraces classes and consultations with the mother giving her information on the dietary needs of the different age groups. In high schools the Red Cross course in nutrition is adopted and upon satisfactory completion of the course the Red Cross certificate is issued.

If the nutrition work is to be carried on from day to day, thus making it a part of the child's daily life and in turn the very center of real community well being, the teacher must have sound information upon which to base her teaching material. More and more during the past five years colleges, normal schools and universities have become interested in the program. As a result many of them are giving two to three points extension credit for those teachers who complete the Red Cross Course in Nutrition for Teachers with a requirement of from thirty hours to forty-two hours of instruction under a Red Cross nutritionist. Indiana University is granting credit to the teachers who are taking the teachers' nutrition course under the Red Cross nutritionist.

It is well recognized that not only is nutrition instruction important for the children but even for the adults. In many communities, available statistics show that malnutrition exists to the extent of 15 per cent to 50 per cent among school children with an average of about 30 per cent, but malnutrition is also prevalent among preschool children and among adults as well, although statistics for these groups are not so easily available.

If as a public health nurse or as some other individual you are interested in bringing to your county such work as has been pictured through this article, discuss this with your own Red Cross chapter. They will recognize and appreciate the truth of the following statement by Dr. E. V. McCollum: "The right kind of diet is the most important single factor in promoting public health; it is the material with which to build the foundations of success."

AN AFFILIATION FOR PEDIATRICS

The Visiting Nurse Association of Elizabeth, N. J., has had an arrangement for student affiliation with the Elizabeth General Hospital since December 1, 1928. The Association has three of their student nurses for a period of three months. These students, while on duty with the Visiting Nurse Association, serve a total of six hours weekly in clinic of the out-patient department of the Elizabeth General Hospital. This work is under the supervision of the V.N.A. supervisor. No other work is required of the students by the hospital except a possibility of one class hour per week. The V.N.A. has full control of the students on holidays and Sundays. All of this is definitely stated in the contract.

The students have one month generalized service and two months pediatrics. The Visiting Nurse Association furnishes the district bag complete except hypo syringe, pays carfare and telephone in the district and furnishes uniform coat. The hospital furnishes the uniform dress, collar and cuffs which is the same as worn by the V.N.A. graduate staff—also uniform hat. The two organizations divide the salary of the supervisor. The Visiting Nurse Association bills the hospital monthly for the amount of the salary due, and pays the supervisor in the routine way. The contract states that the supervisor shall be employed by the Visiting Nurse Association, but her qualifications must meet with the approval of the superintendent of nurses of the Elizabeth General Hospital.

The supervisor's complete time is given over to the three students, the three sessions of the hospital clinic—total six hours weekly, and one of the Visiting Nurse Association clinics which is a Well Baby Station, making a total of nine clinic hours per week. She also gives twelve lectures to the hospital students. During the first month, the older staff nurses help in introducing the students to the field.

The Problem of the Unadjusted Child

By Henry C. Schumacher, M.D.
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THE term "psychopathic" is a broad one. By it the mental hygienist does not mean merely cases of insanity. Insanity, after all, is a legal term—it means that the individual's mental condition is such that he is certifiable under the law. Our use of the term psychopathic, however, includes that great group of conditions known as neuroses, or better, psychoneuroses. This latter group is more familiarly known to the public as "nervous cases" and composes those spoken of as having suffered a "nervous breakdown."

Those working in the field of mental hygiene are definitely of the opinion that a certain amount of these mental disorders are preventable but that in order to prevent them two conditions have been found to be necessary: first, a recognition of early warning symtoms, and second, a proper and efficient treatment of the cause of these symptoms.

Mental hygienists have learned that most of the mental disorders have their beginning in childhood; in those early formative, plastic years of childhood. Furthermore, these mental disorders are the result of a failure on the part of the individual to satisfactorily adjust himself to some given life situation or life situations. This failure to adjust is chiefly on the emotional level. The emotions are much more an influence in mental disorders than is the intellect.

CONCRETE CASE HISTORIES

I shall try, in citing several concrete case histories, to show the need for the recognition of these early warning symptoms and how treatment, to be successful, must be based on a knowledge of the cause of these symptoms.

Kate is a six-year-old girl of German-Irish parentage. She is the third of four children. Kate at six is too troublesome to be kept in kindergarten, according to the teacher, and according to the mother, too much of a problem to be kept at home.

Kate's mother comes from good Irish stock and she feels vastly superior to Kate's father and his relatives. She enjoys talking of her early life and her rich relatives and is constantly complaining about the treatment she receives from her husband. The father of Kate, however, feels very much disappointed in his wife. He states she cannot cook nor sew and hence his family is not as thrifty as his relatives. He denies any abuse of his wife or children but accuses his wife of neglect of home and children. Neighbors and other informants tend to substantiate his statements and to blame the mother for most of the family discord. Discipline of the children is most inconsistent, varying from tender sympathy and overprotection to corporal punishment for the slightest infraction of some foolish command.

This is the home life into which Kate was born. What little training she got ceased at the birth of the youngest child, of whom Kate was quite jealous. Displaced by the newcomer, she did all in her power to make life miserable for everyone. Completely misunderstood by her parents, life for Kate became but a tragic struggle for recognition — in which struggle, as so frequently happens, methods quite socially unacceptable were as fully and readily utilized as those more socially acceptable. Whippings and abuse one moment and

* Read at the Big Brother and Big Sister Federation, Inc., Memphis, Tennessee, May 8, 1928.

caresses the next but intensified her struggle. In this struggle Kate has been most unsuccessful and so has finally come to the point of withdrawing entirely from this world of reality and of living in a world of her own. Perhaps her replies to questions put to her at the time of her first contact with a psychiatrist will illustrate the type of thinking Kate was engaging in.

"*Do you go to school?*" "Yep."

"*When did you go to school?*" "In—uh, uh—in June, in June, in February."

"*Do you go every day?*" (No verbal response) Nods head, shakes head, and nods head again.

"*Are you a good girl in school?*" Nods head, then "Yep, Sunday School."

"*Are you good there?*" "Yea, yea, in the Sunday School there are bad children, bad children. Niggers there, nigger children went to school. I saw that little nigger, baby nigger, baby nigger, that little boy nigger. Maybe he ran, he ran," (keeps muttering to self and making noises with mouth and lips, alternately).

"*When is your birthday?*" "Last Sunday I had my birthday (wrong). I had a box of chocolates and ice cream cones, lots of them. All the time, today, today is my birthday. Today is my birthday (wrong). Today is Friday, Tuesday, Monday, Monday, Sunday."

"*How long have you gone to school?*" "Maybe two years, three years, six years old. Five weeks I go. My brother is home four weeks. The policeman was in school and the schoolmaster took him up town."

"*Are you good at home?*" "I'm going to play in the sand. I'm going on the swings. I go brr, brr, brr, fingo, fingo. A blue car, all time on a blue car, a big car. We going up to—. I'm going in to show with $10, $4, forty, fifty, sixty, $90. Oh, lordy, lordy, or party, portig, porty, lordy. Hay, I forgot my junk, my punk. Maybe the ladies are going home. The men go home. I'm going to eat my dinner now."

As you may have noted, her responses seem to have a peculiar mixture of fact and phantasy. She seems to be diverted in her responses by some internal associations, all of which, no doubt, have meaning for her. There is in all of this, too, a definite attempt at evasion,—a refusal to face the situation, and it is an index of her withdrawal from reality. To many her conversation as above reported sounds queer indeed. However, a knowledge of the home situation and her reaction to it, immediately throws light on the treatment to be pursued. In this home she has failed to make satisfactory emotional adjustments to parents and siblings and plainly shows the carry-over of those maladjustments to school and playmates.

A study of the home environment causes us to feel that a placement away from home was urgently indicated. In the meantime much work would, however, have to be done with the parents looking forward to the return of Kate to the home at some future date. The parents' emotional entanglements were the primary cause of the child's faliure to adjust and these, therefore, must be straightened out if the child is to return to the home. Kate was placed in a "study home." A treatment note only three months later reads:

"She has grown into quite a favorite with the other children. She has responded well to training. She follows in the group. She tends to keep herself cleaner and is proud of any new clothes which she possesses."

And a note a month later reads:

"She is a very likeable youngster. She plays just as nicely with the boys as with the girls. All the children are nice to her. She has stopped being too demonstrative with adults. She is observant of everything going on about her."

Later she was placed in a foster home and there, too, she is making a good adjustment.

TREATMENT AIMS AT THE CAUSE

Why was the treatment successful? Because it was aimed at the causative factors. Just as soon as this child was placed in a situation where she had a feeling of security and in which she got love and affection and a square deal she made a good adjustment, both to adults and to her playmates. Here then is an example of a definitely psychopathic child, a child referred to as

being "queer" by her parents and neighbors, whose reaction trends were the product of her environment and whose patterns changed as soon as she was placed in an environment calculated to change her reaction trends.

THE CASE OF PAUL

Next let us take the case of Paul, aged thirteen years, the younger of two children. Paul is reported to be a very sensitive lad, who cries very easily. A short time before our study he injured his arm and now, although it is physically sound, he refuses to use it.

Why does Paul need to have a paralyzed arm? Could this need have been predicted and what measures should have been instituted previous to the onset of his present mental illness?

Paul's father and mother didn't get along well and finally, after years of quarreling, they were divorced. Both children stayed with the mother and sympathized with her, probably the more because of the unfair stories she told them about their father. Paul is the "baby" in the family and as a result of the domestic friction the mother turned more and more to Paul for comfort and sympathy. Paul accepted this overprotection and came to rely on it. In it he had a sense of security as well as a sense of ownership of his mother.

As he grew up he found it harder and harder to adjust to other youngsters. He was teased and tormented by them. He was called a sissy, particularly when he was seen playing with the neighbors' five-year-old girl. His adjustment on the playground became constantly worse and as a concomitant his school work also became worse. At thirteen the mother began to be a bit critical of him. His bad grades at school annoyed her. His desire to possess her also began to annoy her. He, in terror, began to feel that he was losing out. Then he injured his arm at play. Now again he got attention in overabundance from his mother. Furthermore, it was an excellent excuse for his inability to take part in games. In the class room it served as an excuse for not getting his lessons, since, it being his right arm, he could not write, or again it would suddenly pain so severely he would have to go home.

Of course this boy needed his illness. He knew no other way out of the situation in which he found himself. He had been placed in this situation by his parents, particularly the mother, and then when he needed her most she began to forsake him. He did what every neurotic does. Countless hundreds of our chronic invalids met a crisis in their lives just as this boy did. And their reactions, just as his, could have been predicted had one known their early history and therefore the need the illness would serve.

THE TREATMENT FOR PAUL

The treatment in this case, just as in all others, is based on a knowledge of the cause. Very briefly, after a few contacts with Paul in which he was given some insight into the nature of his condition, he was sent to a camp especially selected for him. There, even under ideal conditions, he found it hard to adjust. He ran away once. But the work done with the mother, in giving her insight into what the real difficulty was, stood us in good stead now. She promptly returned him to camp and was firm, though kind, in her handling of him. Today, after a little over a year's intensive work, he stands on his own two feet; a self-reliant and independent youth. The same kind of treatment, namely that of an ever increasing responsibility, undertaken previous to his definite hysterical breakdown, would unquestionably have prevented that occurrence.

THE STORY OF JOHN

And lastly, let me tell the story of John. John's father was a ne'er-do-well who deserted the mother. The mother, too, was a weak character who, following her husband's desertion, took what she felt was the easiest way out of supporting her family by becoming a mistress. In this immoral home John was the witness of much

sex activity. When he was about ten his mother was probated to State Hospital, a dementia precox victim. John was placed in a foster home. There he engaged in much sex teaching and sex misconduct. The neighbor girl's father complained to the agency and threatened to have the boy brought into juvenile court if he were not at once removed from the neighborhood. John was told that his misdeeds lost him his foster home and nothing further was done to uncover the cause of his misdeeds.

In his next placement he was reminded of his misconduct and told that if he engaged in any of such activity he would go insane as was his mother. Masturbation, he was assured, made people go crazy. The children, learning that his mother was in the state hospital, in teasing him called him "lunatic." His aunt and uncle insisted that he visit his mother, who by this time was living so completely in a world of her own phantasy that she no longer seemed to recognize him. This was the picture that was constantly before him, particularly when a sex temptation beset him. However, as is usually the rule, this did not make it a bit easier to overcome his habit of masturbation, in fact, it increased the frequency and heightened the emotional upset state following it.

At last, at fifteen, we have him referred to a clinic, the boy feeling definitely he is going insane. This boy had a Big Brother assigned to him, but the Big Brother was either ignorant of this boy's mental conflict or felt unable to cope with it. Yet this Big Brother was idealized by the boy. He loved to be with him. He felt the same regrets most boys having Big Brothers (and the same is true for girls and Big Sisters) do when the Big Brother feels his duty done by giving the boy some money and sending him off to the show, there probably to live in a world of dreams and phantasy instead of the world of reality from which he is already tending to escape. Here then was John, laboring under a delusion as to his mental health, yet as a result of that same delusion rapidly drifting into a state of mental ill health from which so few, when well advanced in it, ever return to normality.

Given the facts of John's life history and the attitudes of those whose business it was to aid him in adjusting to life, and anyone at all versed in mental hygiene could have predicted the results and what is of much more importance, could have been ready to so adjust him to his life situation as to prevent his drifting into mental disorder.

ESSENTIALS TO PREVENTION

I am sure there is no need for me to cite any more cases to show that psychopathic cases, in most instances, can be prevented. It does demand, however, a very complete study and understanding of the life history of the individual and the environment to which he must adjust.

Two things are essential: a recognition of early warning symptoms and a proper and efficient treatment of the causes of these symptoms.

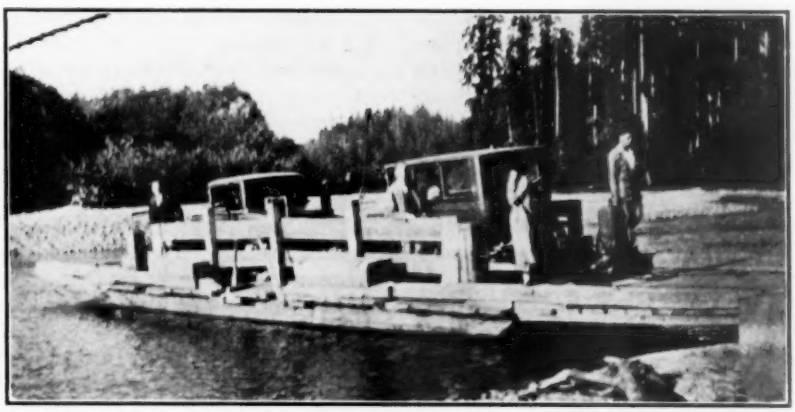
There is no list of early warning symptoms that I would leave with you. It would but be confusing and disappointing. The symptoms are so many and so diverse and have value and meaning only in relation to the life history of the individual showing such symptoms. I would rather that you come to look upon boys and girls as youngsters constantly tending to adjust themselves to the ever changing environmental factors about them, and to regard any deviation in personality or behavior from socially acceptable standards as a warning symptom bearing investigation and then if found wanting to treat not the symptom, but the underlying cause.

An Adventure in Rural Public Health Nursing

By Bertha M. Tiber, R.N.
Jefferson County Public Health Nurse, Port Townsend, Washington

COMING to this Puget Sound country from the Middle West was a surprise and a revelation to me. I have lived here only one year, and at any time yearnings may come for the rolling hills of my homeland, but right now, I can imagine no call loud or sweet enough to take me from this magnificently, mysteriously beautiful part of the world.

My duties as county nurse for Jefferson County give me rare opportunities for outdoor life. From my apartment in Port Townsend, which is really not an apartment but a nest on the edge of a cliff, I can revel each day in the beauties of Mount Ranier, the Cascade Range, Mount Baker and the Olympics. Can you imagine more from one window? And the sunsets! And the sunrises!



The ferry across the Queets

My County

Jefferson County reaches from Puget Sound and Hood's Canal to the ocean, with the Olympic Mountain range extending through it from north to south. I had not been in my county long before I began to hear of the remote but alluring West End, the part of the county that is beyond the Olympics. These mountains—seemingly so close and friendly—are impassable and divide the county most effectively. The people over there are "my people" and I was glad when the county officials planned a visit to them. This trip involves a drive of two hundred and fifty miles by motor through four counties, and later on horseback and then in a canoe.

Clearwater

Clearwater—the largest settlement out there—is easily reached when the rivers are low. It is located on the Clearwater River, which flows into the Queets. As the name indicates the river is clear as crystal, in direct contrast to the Queets, a tumbling eddying river, even at low season. At the present time to reach Clearwater, it is necessary to cross the Queets River on a high suspension bridge, or to take one's car over on an antiquated little ferry. The settlers tell interesting incidents of adventure, when the cables have given away, usually under the hand of a novice, and the ferry and load have been carried to the ocean,

or stopped by a log jam in the middle of the river.

Clearwater country has the heaviest rainfall recorded in the United States. During the rainy season it is therefore dangerous, and sometimes impossible to cross the river. Considerable road work is now being done and a new bridge is being built across the Queets, so this period of adventure will soon be history.

"The Trip In"

Besides the adventure of the journey, my problem was what sort of a health program to institute. A few weeks before, a call had come from a neighboring county to help with some infant and preschool conferences where the nurse had resigned. Of course I went, and found the work most interesting. The mothers were in the habit of meeting at the Health Centers for monthly conferences, at which their children were weighed and measured, progress and gain noted and advice given by local physicians and the nurse. It was a splendid example of health work in a pioneer country, and gave me an inspiration for the program to be established in my own West End.

Arrangements were all made by letter for two days of conferences and it was decided to include as many school children as possible. No work of this kind had ever been done in that district, and a great amount of interest had been aroused as an eminent specialist and the director of the child hygiene work in the State were giving their time to furthering the program. Naturally the people in the West End were looking forward to our arrival.

So, one morning bright and early, I packed my scales and clinic equipment into my county car "Sally," an inherited and temperamental coupé. The County Superintendent of Schools accompanied me. We reached Aberdeen, about a hundred seventy-five miles, with no more serious mishaps than two flat tires, and drove into a garage to have a diagnosis made of a peculiar knock in Sally. As we stopped the car a rear wheel fell off—that, however, was a mere detail. At eight o'clock all was set to start off for the forty-five mile drive to Lake Quinault. It was a glorious journey. At intervals the moon shone, and myriads of white feathery clouds were visible. Then before we knew it, it would be raining again. During one of these downpours, we had another flat tire—another mere detail. We reached the lake and hotel during an interval of moonlight and had a magnificent view of the lake and surrounding country.

The Conference

We were scheduled for conference next day. This country seemed designed for a play ground—it was almost sacrilegious to think of working, but our work proved a great pleasure. By the time we reached the place of conference it was raining as I had never seen it rain before. Since it was the first rain of the season, and the people were accustomed to dryness, it seemed impossible to think of children venturing out. We made our usual preparations for the conference, and learned that Mrs. X, living just across the river, had a tiny baby. She had been most enthusiastic about our coming and was now worried for fear she could not attend. So, we borrowed raincoats to supplement our own, and set out to call on this family. We crossed the river, and were walking toward the house through a beautiful thicket of alders, when we heard a mighty crash, its echo, and soon another crash. We decided that they were blasting either for the new bridge or roads and went serenely on. We were later informed that the crashes were caused by trees falling. The old and partly decayed trees often do that, when they become waterlogged. It was rather terrifying.

We "did" the children and returned to the place of conference. During the afternoon we examined the school children as well as all the infants and preschoolers in the community. A community meeting was

held that evening to organize a Parent-Teacher Association and it gave us an opportunity to confer with the parents of the school children. Our clinician also spoke to the assembly.

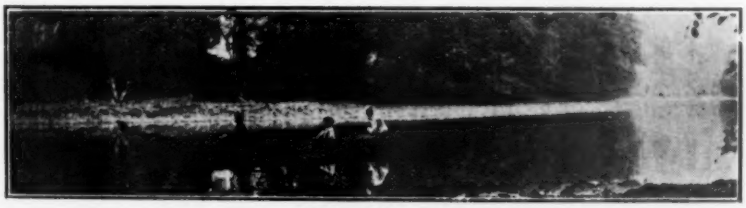
By Canoe

Meanwhile as the rain continued we began to think of the morrow. The plan was to go up the river as far as it was possible to drive, and the children, school age and below, from two districts were to be assembled there. They would be able, under ordinary circumstances, to be brought across the river in wagons. However, we learned that the river had now risen so high as to make fording impossible. It was finally suggested that we go up the river in a canoe to examine the children who could not be brought down. We forded a wide but shallow creek in our car planning each minute who would get out if the engine stopped, and what we would do, getting really alarmed when the engine did stop as we were going up the bank. However, it was just that kind of an engine, and after a bit of coaxing, made the grade. At last we reached the landing and were tucked into a canoe for our three hour trip up the river with blankets and canvases in case it should rain.

Just then the sky was blue and the sun shining. I wish that I could adequately describe that trip. We were going against the current and at times our motor hesitated, and we wondered if we were really going. The vast stillness of the place completely awed us. The only noise was the sound of the motor on our boat, or our own occasional voices. For the most part we were too thrilled to talk. Occasionally gulls would come close enough for us to hear them. An eagle swooped down and seemed to follow our course for a while, and a band of elk fled when they spied us. I shall never forget the brilliant coloring of the vining maples against the dark green of the firs and spruce overhanging the banks, and their perfect reflection in the gray-green glacial water of the Queets River, or its blueness where it seemed more tranquil, and the indescribable peace and quiet that seemed to pervade all.

Our children and their parents were waiting for us. The appreciation and hospitality of these people and the absolute perfection of the surroundings, make it seem a different world. In fact, the isolation does make it a different world. But coming to the practical side of our work—the children and their defects are much the same. One would expect to find conditions worse, a trip to the doctor means miles in a wagon or on horseback—fording that river, always very angry in winter, then sixty-five miles by car into Hoquiam. We could but admire the courage of people with families who undertake pioneering in this country.

We returned to the assembled children of two more school districts—one school of five children, the teacher, and one mother had come thirty-five miles for the event. We could not help thinking that what we gave was little in contrast to the sacrifices these people made to obtain it. However, I returned home from that trip with a feeling of having accomplished something, and with memories of these courageous pioneers and the beauty of their surroundings. It is these experiences, I think, that give us courage and inspiration to carry on over some of the less happy places in our work.



On the Clearwater

Prevention of Heart Disease in Childhood*

By Harrold A. Bachmann, M.D.
Chief of Cardiac Clinic, Children's Memorial Hospital, Chicago

HEART disease has become a definitely established public health problem. Any disease that persistently heads mortality tables is destined to arouse interest. This is the position that heart disease has now held for several years. The disease, however, should not be considered alone as one causing the greatest number of deaths, but rather as one causing enormous handicap, discomfort and restricted activity for the many living subjects afflicted with the condition. Estimates indicate that approximately 2,000,000 in the United States or 2 per cent of the population have damaged hearts. The economic loss, the cost of medical attention, and the compensation paid to many of this great army of cripples, represents many thousands of dollars. Mortality statistics are depressing and sad; morbidity statistics are tragic, for they present a living picture of limited freedom, decreased earning capacity with resulting poverty, and lastly, the deprivation of much that makes for happiness and the joy of living.

Heart disease is a complicated process. The heart mechanism includes many functions and many tissues, any or all of which may become involved. Because of this, we deal with a multiplicity of types, each presenting different symptoms, different treatment, and a greatly varied prognosis. The approach, therefore, is difficult and the problem most intangible for general and widespread propaganda.

There is still much knowledge desired regarding its many phases and vicissitudes. For the present, we are certain that cures are in the main impossible, but we also know that a diseased heart can be made to function with a fair degree of efficiency under a proper regime. And last, but not least, we are not alone hopeful, but convinced that certain types of heart disease are preventable.

When we consider the prevention of heart disease, our thoughts must turn chiefly to the child. The incidence of the disease in children is relatively high. Most of the studies thus far indicate that approximately 1.5 per cent of the children attending public schools have some form of heart disease. Of this group there would be, of course, a certain percentage of congenital hearts over which we could exert no influence except to aid them in carrying on. When, however, we appreciate that a percentage well in the nineties of the rest have encountered the condition due to preventable diseases, we begin to feel that much good work can still be done. Let us consider then what heart disease in childhood is, what its causes are, how it can be prevented, and in what way our energies shall be directed.

CAUSES

Congenital heart disease. This is generally due to some faulty development of the heart in prenatal life. It may be thoroughly compatible with life and many children grow up and succeed, as though no defect were present. For the most part these are the children without cyanosis. Another group of congenital hearts produce cyanosis. Many of these die young, probably from some intercurrent infection, which overtaxes an already loaded heart. A certain few survive, living, however, always with a handicap and never completely free of danger. As a rule, children surviving with congenital lesions are happy and are active up to certain limits. Fortunately for them, they have

* Edith Butler Pool lecture given at the Chicago Nurses' Club, August 7, 1928, before the Staff of the Visiting Nurse Association of Chicago.

grown up with their impairment and in consequence have never known the enjoyment of unrestricted freedom. Activity for them has always been circumscribed and needs seldom to be curtailed, for they sense their limitations and stay well within them.

Acquired heart disease. One can agree almost entirely with St. Lawrence when he says that "Rheumatism is the chief, if not the sole, cause of heart disease in children." This is certainly true after the age of three. Previous to that age, acquired lesions, though rare, are usually septic in origin. After that age, we need concern ourselves with little else. Scarlet fever may be considered in a small percentage, but here very frequently we can trace the condition to some arthritic sequelae following the acute phase. Diphtheria may affect the heart, but rarely with any degree of permanency. If serious involvement has been inflicted, the results are usually fatal. Other infectious diseases may at times reflect themselves on the heart, but the involvement is rarely lasting. So again we revert back to rheumatism as the chief cause of acquired heart disease in children.

RHEUMATISM

What is juvenile rheumatism and how can it be recognized? Rheumatism is undoubtedly an infectious disease caused by a certain streptococcus, or perhaps a group of streptococci. Various organisms have been described and a few, clinically proven. The organism invades the body, probably always by way of the throat and tonsils, and eventually lodges in certain tissues of the body, producing rather definite and concise symptoms. These symptoms vary decidedly, depending upon the tissue involved. The variable symptomatology of rheumatism presents a confusing phase of the disease in childhood. There is sufficient evidence, however, to warrant the conclusion that the rheumatic organism is at the basis of all. We deal, therefore, with a series of so-called rheumatic diseases, all of which should be thoroughly understood and readily recognized. These to be more specific are:

Articular rheumatism. An acute, usually febrile, condition involving various joints. The joints are always painful, but, in the child, only occasionally red and swollen. This pain flits from joint to joint and may be present from a few to many days. It is a good rule to bear in mind that in the child *any joint discomfort should be considered rheumatic until proven otherwise.*

Muscular rheumatism or growing pains. These are the benign pains in the muscles which many children encounter. Perhaps most of them are innocent, but if they recur frequently, they may be of a more serious significance. We constantly see cardiac lesions in children whose only incriminating bit of past history is of this nature. In consequence, growing pains are not to be ignored as previously done.

Chorea or St. Vitus Dance—That well-known acute nervous condition characterized by marked incoördination, emotional instability and speech defects. It is usually insidious in onset, though at times rather abrupt and acute following some fright. *Any emotional change in a child should be a warning of a possible oncoming chorea,* for frequently this precedes the more evident symptoms by days.

Tonsilitis. Not all cases of tonsilitis should be considered rheumatic, nor will all cases cause heart disease. If a child, however, frequently encounters tonsilar infections, the likelihood of a complicating heart lesion increases. Many established heart lesions in children can be traced to this source.

Thus we see a wide variation of the symptom complex of the rheumatic diseases. That they are all rheumatic and that they may all lead to heart complications, our clinical experience bears sufficient evidence. That they can all be recognized early is likewise sufficiently evident. And that early and efficient care will abort the infection and prevent complications is reasonably plausible.

PREDISPOSING FACTORS

Experience convinces us that these rheumatic diseases do not thrive in all environments. On the contrary, they are rather selective and through the appreciation of this selectivity one gains further confidence that the hope of heart disease prevention in childhood is not only plausible but strongly possible. In a private practice group rheumatism and heart disease is extremely rare. In dispensary practice it is not uncommon. If this be the case, certain environmental or predisposing factors must be important.

Dampness. English authorities are convinced that dampness is one of the most important predisposing factors of rheumatism. This evidence is more grossly emphasized in their climate and under their housing conditions than in ours. Observations thus far made in this country bear out the same conclusions, however, and definitely indicate that dampness, especially associated with cold, increases the incidence of the rheumatic diseases.

Diet and nutrition. That faulty diet with resulting poor nutrition is an important contributing factor in all diseases is not a new thought. That is carries a rather specific bearing to the rheumatic diseases, is rather recent. One can well appreciate that poor nutrition and decreased resistance must bear influence upon the health of children.

Poverty. This includes the above handicaps and many others that pertain to factors that retard the attainment of a healthful life.

Contagion. Evidence would indicate that contact with rheumatic diseases increases the incidence of said diseases. In 50 per cent of the families in which these conditions have been observed, two or more members have been afflicted with some phase of the disease. Another study showed that 8 per cent of the people exposed in family groups to the rheumatic diseases had some type of the disease. Contact and contagion are important predisposing factors and though the environmental factors may be the true explanation, we must remain keenly alert to the contagion possibilities.

Intelligence and indulgence. These are among the most important environmental factors. In the private practice groups each infection, however mild, is checked and intelligently guided. In the dispensary group these are largely neglected. As a result, they lead not only to a more protracted illness, but also to a gradual lowering of resistance, making the patient more prone to sub-acute and chronic infection.

To sum up, we may say that environmental factors bear a direct influence upon the incidence of the so-called rheumatic diseases. It is always surprising the dearth of heart disease and the allied rheumatic conditions one encounters in private practice. This, I feel, is definitely due to the improved environmental surroundings of this group. Infections lurk in both, but rheumatism is rare where the home influence, comforts and hygiene are well regulated and organized.

TREATMENT

Treatment should be one of prevention, while prevention should involve alertness and attention to the minor illnesses and aches of childhood. Neglected infections are of paramount importance and especially if they occur in the less fortunate environments.

When articular rheumatism appears or when chorea is present, rest still remains the outstanding specific method of treatment. The rheumatic child suffering with joint pains should be confined to bed and remain there until not only the pains are gone, but no temperature has been present for at least 10 days. A rectal temperature of 99.8 should be considered in the rheumatic child as evidence of a remaining infectious process. The choreic child needs an extended rest of from 5 to 7 weeks. When a rheumatic carditis is present, the indications for more extended rest should be determined by the attending physician. It is well to remember that it is better to keep a rheumatic child in bed too long than not long enough.

The treatment of the established cardiac child is a separate problem and will not be discussed in detail here. Consider with him, however, that any intercurrent infection, even a simple cold, should be of sufficient importance to warrant bed care.

There should always be an estimate made of the functional efficiency of the heart. A rather ready evaluation of this estimate is found in the weight curve of the afflicted child. *Weight loss is an omen of significance and must not be ignored.*

Foci of infection demand in the rheumatic child prompt and efficient treatment. Tonsils and adenoids call for removal and carious teeth for attention. The infection may not thus be eliminated, but the danger of recurrences is decreased. The character of the tonsils must not alone be the criterion that guides the decision for removal. The history, the general health, and the environment are far more reliable factors. I do not recommend an indiscriminate removal of tonsils, but I do urge a fair evaluation of their clinical appearance and the contingent factors bearing upon the case.

PROGNOSIS

All children encountering the rheumatic diseases do not develop cardiac complications, providing proper treatment has been instituted and enforced early. Recurrences, however, are common and with each there is greater likelihood of cardiac injury. Approximately 75 per cent of the children encountering arthritic rheumatism develop cardiac lesions. Following chorea, about 30 to 50 per cent develop the same complication.

An established cardiac lesion, once begun, is rarely healed, though it is possible for the cardiac function to be only slightly impaired and a normal life enjoyed. The prognosis of the truly cardiac child becomes guarded with each intercurrent infection, whether it be intracardiac or extracardiac in origin.

CONCLUSION

Our interest in the cardiac problem should come through the morbidity statistics rather than those based on mortality. We must seek to aid and prevent the cardiac cripple whose very existence is an economic loss and a depressing family burden. The prevention of heart disease, especially in childhood, has been sufficiently proven. We can find evidence of this impressive fact by a casual survey of the better classes in whom heart disease is rarely encountered among children. The influence of environment on rheumatism in childhood is of greatest importance, in fact, it is of such great moment that *rheumatism in the child should be considered an environmental disease and problem.* For the untrained worker, for the trained nurse and for the physician himself, a more thorough understanding and appreciation of these environmental influences will net far greater returns in this new field of preventive medicine than any other single factor.

The Visiting Nurse Association of Chicago is doing some special follow-up work for cardiac children who have been in Sunset Camp at Antioch Lake, the boys in the spring term and the girls in the fall. The first call is made by Miss Martha Jenny, who has been the special cardiac nurse for nearly two years. She types a very brief history of the case on a pink record slip, attaches it to a marked copy of Dr. Bachmann's article and sends it out to the sub-station. The supervisor sees that it goes out to the nurse in the general district. Follow-up reports are sent to Miss Jenny, emergency messages telephoned, otherwise written. Miss Foley writes:

"Gradually we are getting a heart consciousness that is very desirable and helpful. Since tuberculosis as a specialty seems to have made very little impression on nurses and nursing, I am hoping that our way of visiting the cardiac child will help all of us to know something about their aftercare as well as the prevention of conditions which are so frequent and so needless."

What A Situation!

Foreword: The successful handling of the problem of enuresis by mental hygiene tactics, where no physical disability or disease is present, has become a matter of rather common occurrence with the Henry Street nurse; dealing with this problem has about slipped into the background of routine procedure. The following story sent by the Mental Hygiene Supervisor of the Henry Street Visiting Nurse Service is worth noting, not only because of the six youngsters involved, but also because of the skilful way in which the nurse secured the coöperation of every member of the family.

ONE hot, stuffy day last June, the Henry Street nurse from the Hamilton Center, down on the Lower East Side of New York, went to see the Papadoupolos family for she was interested in checking up on the two youngest girls who had attended her Pre-School Clinic. The nurse found twelve year old Louise tugging away in a valiant attempt to wring out some heavy wet sheets. Louise was in charge of the house that day; Mrs. Papadoupolos had gone out to work in an embroidery factory in the neighborhood. Although the father was doing fairly well in his little tailoring shop down at the corner of the street, it was sometimes good to have extra money for clothes; it is not such a simple matter to keep six little girls looking clean and neat and well-dressed. Helen, the fourteen year old, and the eldest of the children was at summer school for she wanted to make up enough work so that she could graduate from the eighth grade at the end of the coming semester.

As Louise tugged at the sheets, her face red and hot from the exertion, she told the nurse what she thought of her two little sisters who wet the bed every night and caused her all this extra labor. The nurse not only sympathized with her but suggested some ways and means of dealing with this troublesome problem. Louise listened attentively and promised to follow the nurse's directions. The nurse assured her that if she tried faithfully she was quite confident that her efforts would be rewarded and that she would be relieved of the wet sheets, for the Henry Street nurses are adept at taking care of little bedwetters, helping them to overcome the bad habit and to wake up in the morning dry and comfortable. Of course, it takes effort on the part of the children themselves, and in the case of very little children, it means that the mother or some older person in the household must be responsible for carrying out the regime.

The first step is a thorough physical examination for the child, either by a private physician, or if the family cannot afford that, at a clinic. If no physical cause for the enuresis is found, then the nurse may feel safe in going ahead and attacking the difficulty as a mental hygiene problem.

Louise was true to her promise. In just two week's time, three year old Hilda and four year old Marjorie were sleeping cosily together in their little folding bed as dry as bones. They were young and healthy and bright little girls and the task had not been too difficult.

No Respecter of Age

Later in the summer, the same nurse dropped in for another call. This time Mrs. Papadoupolos was at home. She greeted the nurse beamingly as an old friend and insisted that she would make her a cup of the strong, sweet black coffee that the Greeks drink on all occasions. The nurse mentioned the splendid work that Louise had done with the two little sisters. "Yes," replied the mother in her very broken English, "It was good." "But perhaps she did not tell you that she too is a wetter? That all the girls wet, even smart Helen who goes to Junior High this next year? She would tell on the little ones but not on herself and Helen."

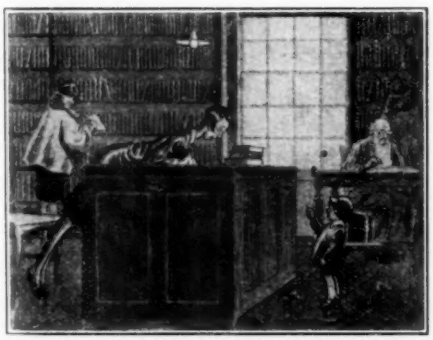
What a situation! Here was a job indeed, and the nurse lost no time in

getting down to business. She talked with the mother, and when the mother's English was about at the breaking point, the two of them went downstairs to take the father into consultation. Mr. Papadoupolos put down his shears, listened attentively, explained the nurse's instruction to his wife and promised to help.

That was the beginning of a real campaign for dry enforcement. Once a week the nurse made a brief call at the home, on a Saturday morning so that all six of the little girls could gather around the big table in the kitchen to show their friend their "star charts" with blue stars to mark the dry nights and red to designate the wet ones. If a child had seven blue stars in a row, indicating that her bed had been dry for a whole week, she was given a big gold star to paste at the end of the column. There were tears and smiles and frowns around that table. Mr. Papadoupolos came up from his shop to take part in the family ceremony, and the mother would leave whatever she was doing to watch. At the end of seven weeks all six little girls received gold stars, and now for a month, there has not been a single wet sheet in the morning in the Papadoupolos establishment.

As a special reward, the two little girls were invited to the Christmas party given at the Center office, and the four older ones, who on account of years could not qualify as preschool youngsters, were invited to come anyway and act as assistant hostesses, which after all, is better than being a mere guest.

GOOD MENTAL HYGIENE IN CHILDREN



Courtesy of Saturday Evening Post

Librarian—"I'm sorry—all the copies of Freud are out."

Remember that what your child is in temperament, up to 10 and 12 years of age, usually indicates what he will continue to be all the rest of his life. Temperaments are moulded, not born. *You*, as his parent, can mould him during these flexible years into almost anything you desire.

A spoiled child generally means he has selfish, neurotic or thoughtless parents.

Begin your anti-spoiling methods early. A child can be as thoroughly spoiled at 2 months as he can at 4 years.

Don't "show off" your child before company. Even tiny babies soon learn by this to demand excessive attention.

Give him some responsibility each day and insist that he carry it out. This encourages self-reliance and fosters pride of achievement.

All praise and no blame makes Jack a conceited boy. Praise your child when he merits it, of course. But don't forget the beneficial effects of occasional constructive criticism, or even punishment.

Most selfish, disagreeable, conceited or unreliable adults were once spoiled children.

Don't always do for your child those things he should learn to do for himself.

To "give in" habitually to your child is not an evidence of real mother-love. More likely it is proof that you prize your own immediate comfort above your child's future welfare.

Don't determine to give your child all the luxuries and advantages you may have lacked in your own childhood. Make him earn some of them.—*Health Bulletin, A.P.H.A.*

Steps in Planning a Health Education and Publicity Program

THE FACTS — HOW TO DECIDE WHAT IS TO BE TOLD *

By C.-E. A. Winslow, Dr.P.H.
Professor of Public Health, Yale School of Medicine, New Haven, Conn.

IT is my special function to discuss the factual material to be used in this campaign, to suggest criterions by which we may select the particular things which we wish to tell the world. This is, after all, a somewhat important consideration if publicity is a means and not an end in itself. The points we select should be true, important, comprehensible, acceptable, and usable. These five criterions I should like to consider briefly.

FACTS

First, our facts should be facts. All truth is relative, but we can at least strive to escape the cruder errors of the past. We can avoid giving the impression that litter and paper in the street and in the back yards are likely to produce disease; that dust is a fertile source of infection; that dental caries bear an inverse relation to the use of the tooth brush twice a day. On the other hand, we should not be too eager to introduce into our programs of popular education the newest suggestions of science before they have become established and accepted. We should be careful about advocating the indiscriminate use of iodized water or salt, or of scarlet fever serum as preventives. We should be cautious as to our statements regarding the relation between neglected tonsils and infections of the heart. These, and many more things which are interesting us at present, may prove to be true; but only after thorough thrashing out of all opposing scientific points of view should we shout the conclusions of science into the public ear. As Polonius tells us—" Be not the first by whom the new is tried, nor yet the last to cast the old aside."

IMPORTANCE

Second—our facts should be important. The statement of even an unquestioned truth with over-emphasis may often prove misleading if we do not bear in mind the relative proportion of different truths and their probable effect upon the public mind. It is true that clean milk is better than dirty milk and for children it is probably more healthful. It is probably true that tuberculin testing of cattle is a useful mode of protecting these animals against one of their commonest and most serious diseases. It is not, however, true that clean milk from tuberculin tested herds is necessarily or probably safe milk for human consumption. There is only one safe milk—that which has been made safe by heating. This is the important fact for the public to know. If emphasis on the other and lesser facts obscures this one, we are doing harm and not good.

In our program of public health education as a whole we may properly ask for something even more than accuracy of emphasis in regard to each particular problem. We may also demand that each problem emphasized be set into a general scheme which will make for a comprehension on the part of the public of the broad and fundamental principles which underlie the promotion of health and the prevention of disease. There are, I believe, some dozen such principles which we

* Paper from a symposium of the Public Health Education Section, American Public Health Association, at the Annual Meeting, Chicago, October, 1928, published simultaneously in the *American Journal of Public Health*. Miss Delavan's paper, "Audiences—How to Select and Classify Them," appeared in our May number.

should like every member of the community to grasp, and we may properly consider how each element in our educational plan contributes toward building up these basic attitudes.

We must, for example, make sure that *our educational program as a whole tends to further an understanding of the established elements in personal hygiene.* We want our public to understand the importance of diet as a basis of sound health, an importance which we are realizing more and more fully with every passing year. There are few things which would accomplish more for health promotion than an increase in the consumption of milk, fruits and green vegetables. We want our public to understand the rôle of cool, moving air as a factor in the hygiene of the skin and as an important element in promoting resistance against respiratory infections. We must emphasize the value of exercise and the hygienic significance of sleep and rest. We must keep in view the novel, and as yet only half understood, principles of mental hygiene. In this field we are not only missing invaluable opportunities, but we are often perhaps doing positive harm. I remember a poster which I once saw representing a foreman administering to the worker with a large spoon "His daily dose of lead." Such a poster tends to create mental disease more than to control industrial poisoning.

Our main objectives should also look toward a comprehension of the ways in which communicable diseases are spread and in which they may be controlled by the protection of water and food supplies, the elimination of insect carriers of disease, by isolation and quarantine, and by such habits of personal cleanliness as tend to guard the gateway of the mouth. Above all, we must work for a real comprehension on the part of the public of the principles of vaccine and serum therapy.

Another set of principles which should be basic are those which relate to the relation between the physician and the patient. We should do everything that we can to build up the idea that the physician is a trainer and not a repair man, and to show how, from the prenatal period through infancy and school life, in industry and in the decades of degenerative disease, the principle of health examination is essential to a maximum of health and efficiency.

Everything that we include in our health education program should consciously lead toward the building up of a knowledge of principles of healthy living, and this program should be so organized as to cover them all with reasonable completeness in any period of a year.

SIMPLICITY

Third—the facts we teach should be comprehensible to the man in the street, and not merely to the statistician, physician, or sanitarian. Statistics addressed to the general public should be simple and obvious in their bearing. Lists of the number of cases of communicable disease occurring in a city or state during a given week have a charm beyond my personal comprehension. From the public health standpoint, they are almost meaningless, but they apparently appeal to the average reader like the box score of a baseball game. They give the impression that something is happening. They form current news. On the other hand, proportions and averages mean little or nothing to the average reader. Specific individual cases with the human appeal carry far more effectively than most statistics, and many visiting nurse associations are obtaining splendid health publicity with data of this kind. In general, our material should be simple and concrete, and our programs so planned that one lesson at a time may be hammered in, before the public mind is confused with some different and perhaps conflicting issue.

MOTIVATION

The fourth of our criterions is, that the facts we select for our educational program should be emotionally acceptable. If we are to accomplish results,

it is essential not only to catch the interest of the hearer but to arouse in him a desire to attain the aim set forth. There must be motivation as well as intellectual conviction. In considering this aspect of the problem we should lean more heavily than we have done upon the psychologists and the professional educators.

PRACTICABILITY

Finally, as our last criterion, it is perhaps scarcely necessary to emphasize that the facts which we teach should be usable. In dietary instructions it is not of particular value to urge the drinking of milk in a southern industrial community where no milk can be obtained. It is futile to advertise toxin-antitoxin treatment of children unless there are clinics where the treatment can be administered. It is useless to urge an adult to go to his physician for a health examination, unless there is some reasonable probability that when he goes he will get one.

CONCLUSION

The object of our whole program is, I take it, to change the conduct of individual men, women and children. We want them to manage their bodies well; to help us check communicable disease; to use preventive medical service; and to support the community program of health promotion. In the factory, it is possible to analyze every industrial operation into the simple exposure form of a raw material to a tool or a process with the production of a finished product. Our raw material is ignorant human nature; our finished product is the citizen trained in healthy living. Our tools are our bulletins, newspaper articles, lectures, radio talks, and cinema showings. The facts that they teach must be true and important or the educational process will not be worth the cost. They must be comprehensible, acceptable, and usable, or there will be no effective educational process at all.

We are interpreters between the vast resources of health science on the one hand and the individual in the home and the factory on the other. We must keep both things in view. We must believe in both. We must have faith in the message we deliver. As Richard Cabot once said, I think, of social service, we must feel that we have something "too hot to hold." We must also believe in the educability of the common man, or our efforts will be spiritless and futile. It is these two faiths—faith in the cause, and faith in human nature—which make the health educator. Whatever our technique, whatever our rigidness of self criticism, we must add at the end that quality of enthusiasm—a word which in its derivative sense means an inward god. The work of translating the lessons of science into human conduct is indeed a godlike one. If we fully realize its significance, we shall not fail.

We cull these bits from nurses' reports in South Carolina:

I was called in to give advice as to how to help care for an old lady who has a broken hip. They hung a rope from the wall for her to pull herself around by, had a free wide strip of cloth under her to help in moving her and a cow bell on the bed for a call bell.

This comes from a lady whose former servant, now a midwife, came to her to ask if she would order her a baseball mit from Sears, Roebuck and Co. When asked what she wanted with a baseball mit she said that the nurse had said she must have a glove to "catch the babies in."

A CORRECTION

Attention is called to a misstatement in the February number of THE PUBLIC HEALTH NURSE, page 73. The total budget for all the county nursing work in the Monmouth County Organization for Social Service should have read as follows—$102,000 instead of $70,000 which only covers a part of the service.

The Battle Against Diphtheria

News from the Front Line Trenches

THE decline in diphtheria mortality is a notable achievement of preventive medicine. The use of antitoxin for therapeutic and immunization purposes and more recently, the production of immunity by the use of toxin-antitoxin, have contributed largely to a fall of the diphtheria death rate in the United States Death Registration Area from 43.3 per 100,000 population in 1900 to 7.8 in 1927.

The Metropolitan Life Insurance Company reports that in 1928 scarlet fever and diphtheria registered lower death rates than were ever before in evidence for these diseases among the children of American and Canadian wage earners. The new low point for diphtheria followed an increase in 1927, which was disturbing to public health workers because it broke a decline which had continued since 1921. The present indications are that, as immunization of children with toxin-antitoxin becomes more and more general, the death rate will drop steadily.

Like all problems of transmissible disease, this one involves more than the physician or the health department. It needs particularly an enlightened public. Fundamentally the campaign is an educational one. The basis of such an educational campaign is the instruction of parents regarding the value of immunization so that they will take the steps to have their children properly treated with toxin-antitoxin. This is a job for the volunteer organizations as well as official groups quite irrespective of their other functions.

In the twenty-two upstate counties in New York which have reported no diphtheria deaths for 1928 the general practitioner must be credited with his glorious achievement and to him and to the pediatrician we must look for the future success of immunization. In localities where intensive immunizations have been carried on with great success, no one should feel that the work is complete, when in reality it has only caught up with arrears and the real work of preventive immunization of the yearling and the preschool child has just begun.

A COUNTY CAMPAIGN

The experience of one county nurse in the toxin-antitoxin campaign is sent us by Mabel G. Freeman, County Nurse for Orange County, Warwick, N. Y.

A county nurse has many opportunities in her contacts with infant, preschool, and school children, doctors, public officials, and the press, to sell the idea of banishing diphtheria in the next few years. Of course, it entails an endless amount of work to visit from house to house, either in a city or a remote rural district. She must give talks to all types of organizations, plan every detail of the clinics, so that the doctors will need only to give an hour or so of time at each clinic. If a routine is well carried out, a nurse will find that nearly every doctor will give his fullest coöperation.

For the past few years Orange County, New York, has been carrying on an intensive program to banish diphtheria. The county nurses, health officers, and private physicians have talked and practiced "prevention." They have established free clinics where children were inoculated; private physicians have immunized many in their offices; all county papers have been liberal with anti-diphtheria news; the Outdoor Advertising Company has given space for large posters; in fact, every one in Orange County has worked for the eradication of diphtheria. When Dr. Frank W. Laidlaw, State District Health Officer, compiled a few statistics, the decline in the county diphtheria cases and death rate was shown to be very marked. About 19,000 children have had toxin-antitoxin at public clinics.

Many times during the campaign against diphtheria, one may feel pessimistic and think "Oh, what is the use!" Read over Orange County's statistics and be an optimist! During the past five years 520 diphtheria cases occurred in Orange County, and 65 deaths resulted. The record by years is as follows:

1924—123 cases, 12 deaths, 9.6 death rate per 100,000
1925—230 cases, 33 deaths, 26.3 death rate per 100,000
1926— 97 cases, 13 deaths, 10.2 death rate per 100,000
1927— 50 cases, 5 deaths, 3.9 death rate per 100,000
1928— 20 cases, 2 deaths, 1.5 death rate per 100,000
18,489 persons have been inoculated in Orange County
4,985 preschool age children have been inoculated in Orange County.

IN THE SCHOOLS

On the coast, at Bakersfield, California, the nurse inspector of the Kern County schools sends us this effective poster designed in colors by the special art class of the Richland School and we quote a part of the poem which she composed in telling the dramatic story of carrying the diphtheria serum to Nome.

GUNNAR KASSON AND BALTO

"Balto"—said Gunnar Kasson;—
"A lot depends on you.
The mothers and fathers of dying kids
Are praying that we get through.
You've never failed me, old pardner,
Keep mushing along, that's all—
Just keep on lifting one foot at a time
And get up again if you fall."

This is the clear voice of Kasson,
To Balto the brave and strong.
Great Balto's heart made answer
As he strained at the leathern thong.
And over the great wide world, they say,
Broadcast to the anxious throng,
Went the word that Kasson's dog team
Was bravely mushing along.

They battled the fury of the wind,
The sharp ice and the snow:
The deadly cold that stifles the breath:
The pack ice's treacherous floe.
Staggering—snow blind—frozen—
With bleeding ice cut feet,
They lurched into Nome mid the cheering
Of the waiting crowds in the street.

—MARY B. WILLIAMS

THROUGH EDUCATION

Moving eastward we find Detroit waging an educational offensive. The City Health Department issues the following statement which other communities may wish to copy:

Since there are a number of rather common misconceptions concerning diphtheria protection, it would seem wise to clearly state a few of the more important things we should know concerning it:

1. Toxin-antitoxin is used to give long time, for all practical purposes permanent, protection against diphtheria.

2. Toxin-antitoxin does not give immediate protection. It takes from eight to six months before protection is fully developed. The toxin-antitoxin treatments consist of three doses, the doses being given one week apart. Approximately 80 per cent of the children given this course of treatment are rendered immune within six months, the remaining 20 per cent will need a second series of treatments.

3. The Schick test is a scientific means of determining whether or not protection against diphtheria exists. It does not itself give any protection whatsoever. It should be given to all children six months after toxin-antitoxin has been given. This is particularly important because as we said, approximately 20 per cent will need a second series of treatments before protection is obtained and the Schick test is the only means of determining which these children are.

4. Toxin-antitoxin should not be confused with antitoxin. Antitoxin is used for the cure of a case of diphtheria and for the protection of persons who have been definitely exposed to the disease. It gives only temporary protection for two or three weeks or at best a month; it is no good thereafter.

5. An attack of diphtheria does not insure against a second attack. Simply because you have had diphtheria is no assurance that you will not have it again. Many people have diphtheria more than once.

6. Toxin-antitoxin should be given to all children between six months and ten years of age and six months later a Schick test should be made.

THE EYES OF THE RUNABOUT CHILD

One out of every five children examined by a competent oculist will be found to have defective eyesight to a degree sufficient to render glasses imperative if he is to be saved from serious eyestrain. It is abundant justification for the contention that every child, before commencing school, is entitled to an examination of vision by a competent oculist, not merely by an optician. Many a child whose sight is normal on starting to school suffers a distinct injury from ordinary school conditions, to the extent of being a sufferer from defective vision long before school days are over.

A fair estimation of the vision of a year old child may be obtained by means of the ophthalmoscope. Even with older children of the runabout age, the coöperation given by reading can be obtained before reading has been mastered, by means of two simple devices. One of these, the Evans optotype, involves the employment of an alphabet made up, not of letters, but of five little figures: the circle itself, the bird, the apple, the man, and the cat. The child familiarizes himself with these figures, which are given him on a slip of paper a few days before the examination, so that when he sees them on the wall chart, he at once recognizes them as old acquaintances and calls them out as confidently as his elders call the letters of the alphabet.

An even simpler device consists in having the letter E displayed in four different ways. (See THE PUBLIC HEALTH NURSE, March, 1928.)

The defects found may be any possible combination of the three basic disabilities. These three are: far-sightedness, near-sightedness and astigmatism. If these errors are allowed to continue unchecked, there is forced on the unwilling patient an involuntary struggle of the muscles within the eyeball to overcome these unconquerable lens errors. The result of this constant muscular contraction is eyestrain, headache, sometimes even nausea and vomiting.

It is surprising how early a child who needs them can wear glasses. By the simple device of placing eyelets or rings in the templets of spectacles, passing a tape around the back of the child's head and tying each end of it into one of these rings, a year old child who needs glasses can wear them with perfect comfort and with no more frequent breakage than occurs with older wearers of glasses.

When the time comes that people go to the oculist as many sensible people now go to the dentist, for an occasional check up, the oculist's score of 100 per cent glass-fitting will be appreciably lowered.

—Frank Howard Richardson, in *Hygeia*, January, 1929.

The Medical Examination of Preschool Children

By Gertrude A. Pavey, R.N., M.A., and Julian D. Boyd, M.D.
Iowa Child Welfare Research Station and Department of Pediatrics,
State University of Iowa

FOR some time a health program, consisting of medical examinations, nurse's inspections, and special courses in hygiene, has been included in the work carried on in elementary schools. Such a program is being developed by the Iowa Child Welfare Research Station. For several years the children in its preschools have been inspected daily by a trained nurse, and medical examinations have been made under the guidance of the Pediatric Department of the Medical College of the University. These observations have served as a basis for teaching desirable health habits, and to direct such corrective and preventive measures as each child's condition required.

THE PROGRAM

For the year 1927–28 the writers directed the program for routine medical examinations in the preschools of this Station. These examinations were made individually, by appointment through the physician acting as health adviser for the preschools. To prevent the medical examinations having any connection in the children's minds with the preschools, examinations were made at the Children's Hospital, the parents themselves accompanying their children. This procedure eliminated the necessity of interrupting the day's program at the preschools and saved time for the members of the staff of the Children's Hospital and Research Station. The physicians made the examinations in familiar surroundings with all of the necessary equipment and talked directly with the parents, thus avoiding any misunderstandings.

Examination blanks were devised which called for the information most needed in determining the physical condition of the child and in guiding his health. Such items as urinalysis, blood counts, and blood pressure were omitted, except when symptoms warranted further examination. The examining physician recorded the items as found in the examination, and also made verbal and written recommendations for correcting any evident physical defects.

The examinations were given to 93 preschool children ranging in age from 24 to 69 months. The data are reported by age groups as follows:

	Ages	
Group 1	24–42 months	39 cases
Group 2	43–54 months	24 cases
Group 3	55–69 months	30 cases

In the discussion following, the group number refers to the corresponding age limits indicated above.

THE FINDINGS

The past medical histories of nine of the children, as obtained from the parents, were negative for any noteworthy ailment. Two of these were in Group 1, five in Group 2, and two in Group 3. Among the others, contagious diseases and upper respiratory infection had been quite prevalent.

The incidence of contagious diseases in these children is summarized in Table 1.

TABLE 1. Incidence of Communicable Diseases in the Histories of 93 Preschool Children and Their Distribution According to Age Groups.

Disease	Group 1 No. Cases	Group 2 No. Cases	Group 3 No. Cases	Total
Whooping Cough	12	5	13	30
Chickenpox	6	7	8	21
Measles	6	5	6	17
Mumps	0	0	4	4
Scarlet Fever	0	2	0	2
German Measles	1	1	0	2
Influenza	0	1	0	1

The prevalence of communicable diseases among children of this age emphasizes the importance of immunization procedures and tests for susceptibility to these diseases. From information obtained at the time the medical

examination was made it was found that a number of children had already been immunized against diphtheria, smallpox, and scarlet fever. Table 2 shows the distribution of immunized children according to age groups.

TABLE 2. IMMUNIZATION OF 93 PRESCHOOL CHILDREN AGAINST COMMUNICABLE DISEASES PREVIOUS TO THE MEDICAL EXAMINATION.

Disease	Group 1 No. Cases	Group 2 No. Cases	Group 3 No. Cases	Total
Smallpox	9	10	15	34
Diphtheria	11	9	8	28
Scarlet Fever	1	1	0	2

The examining physician recommended immunization against these diseases whenever it had not been previously done.

In Group 1, frequent colds were reported in eleven cases; two in Group 2, and five in Group 3 gave similar histories. Twenty-three gave a history of chronic tonsillitis. Five of these were in Group 1, seven in Group 2, and eleven in Group 3. Twenty of these children had had the tonsils removed prior to their examinations. As probable sequelae of upper respiratory infection, there were seven instances of otitis media, two of pneumonia, and two of croup. Other disease conditions stated in the histories included three cases of chronic diarrhoea, and one of pyelitis.

Several questions were asked to determine the nature of the child's reaction to his environment, and the type of hygiene practiced in the home, particularly as to eating and sleeping. In many instances the information so obtained was apparently of a normal character, but there were several instances of excessive activity, often associated with inadequate rest. There seemed to be some correlation between these factors and the incidence of enuresis. In Group 1 enuresis occurred occasionally in twelve cases and habitually in eight. There were four occasional cases reported in Group 2. In Group 3 there were three occasional cases and one habitual.

The medical examinations, together with the height and weight measurements, indicated that seventy-eight of the ninety-three children were of average weight, eight overweight and seven underweight for their height, according to the Woodbury Tables.* Those who were 6 per cent or more below the average were considered underweight, and those who were 15 per cent or more above the average were considered overweight. Suggestions as to diet were given to the parents of those children over and under weight.

The heart examination showed that there were five instances of systolic murmur in Group 1, three in Group 2, and one in Group 3. None of these were associated with evidence of dysfunction.

The hemoglobin concentrations, as indicated by the Tallquist method of determination, showed the following distribution:

65–69 per cent	3
70–74 per cent	11
75–79 per cent	18
80–84 per cent	33
85–89 per cent	17
90–94 per cent	2

Nine cases were not reported, due to the fact that the parents objected to the procedure.

Enlarged or diseased tonsils were observed in 48, or slightly more than half of the children examined. Twenty of these were in Group 1, fifteen in Group 2, and eighteen in Group 3. Twenty gave evidence of tonsil removal, but in several of these children other areas of enlarged lymphoid tissue had appeared.

The condition of the cervical lymph glands confirmed the evidence of upper respiratory infection. Fifty-one children had enlargement of these glands, which in most instances were tender. The distribution of cases, together with involvement of other gland groups is indicated in Table 3.

TABLE 3. LYMPHATIC GLAND ENLARGEMENTS FOUND AMONG 93 PRESCHOOL CHILDREN.

Glands	Group 1 No. Cases	Group 2 No. Cases	Group 3 No. Cases	Total
Cervical	17	18	16	51
Inguinal	3	2	2	7
Axillary	3	2	2	7

* Woodbury, Robert M.: Statures and Weights of Children under Six Years of Age. Children's Bureau, U. S. Dept. Labor, Pub. 87, Washington, 1921.

Few notations were made in regard to the condition of the nose, ears, abdomen, joints, skin, lungs, extremities, muscle tonus, or nervous system. This would indicate either that these children were free from obvious disease conditions involving these areas, or that the questions on the examination blank were not specific enough to yield detailed information.

THE FOLLOW-UP PROGRAM

In almost every instance health recommendations were made by the examining physician. The follow-up program reveals some very encouraging results with regard to immunizations. Table 4 shows the number of cases according to groups which have been immunized since the medical examinations.

TABLE 4. THE NUMBER AND DISTRIBUTION OF CASES ACCORDING TO AGE GROUPS RECEIVING IMMUNIZATION AS RECOMMENDED BY EXAMINING PHYSICIAN.

Disease	Group 1 No. Cases	Group 2 No. Cases	Group 3 No. Cases	Total
Smallpox.....	15	7	10	32
Diphtheria.....	21	9	8	38
Scarlet Fever.....	17	11	6	34

One feature of the follow-up program is a determination of the success of immunizations. Smallpox vaccination, of course, had an immediate reaction which determines whether or not there is a "take." For diphtheria and scarlet fever there are the Schick and Dick tests to determine whether immunity has been acquired. These tests are to be done approximately six months after the injections. Where immunizations have been unsuccessful they will be repeated.

The follow-up program shows that although tonsillectomies were recommended in a number of cases only four have been done to date. Adenoids have been removed in two cases. In many instances parents have indicated their intention of following the advice of the physician and have made arrangements to have this done at the end of the school year.

IS IT WORTH WHILE?

That a health program including routine medical examinations is worth while for preschools is evident from the foregoing data. The increase in the number of children immunized against communicable diseases would alone justify the extra effort which it involves. It has previously been established that children entering the first and second grades have more physical defects than any other groups.* This period is not one characterized by physical unfitness, but the conditions which exist are due to the fact that between the ages of two and six the child is neglected. A program such as has been described means that when these children enter the first grade they will, without doubt, be in better physical condition than the average run of first grade children.

*Clark, Judith: Safeguarding the Health of the Preschool Child. Jr. Am. Assn. University Women, March, 1925.

TROUBLES

Stockings are a trouble—so many times my toes
Try to climb in where a heel generally goes.

And mittens are not easy, for lots of days my thumbs
Go wandering and crawling into other fingers' homes.

But rubbers are the hardest, because it seems to me
I always put one rubber where the other one should be.

—Dorothy Aldis

Personality and the Social Worker

Editor's Note: One of the most difficult subjects on which to secure information for our readers, and one of the most sought after, is that abused topic—personality development. We congratulate ourselves, therefore, on having found an article in *Mental Hygiene* for January, 1929, by Helen I. Clarke, who is Assistant Professor of Social Case-Work, Department of Sociology, University of Wisconsin, which seems valuable in that it is sensible and authoritative. We quote liberally.

LIKE most other good words, "personality" has been cheapened by easy and unthinking usage. We need not, however, necessarily banish the word from our vocabulary on that account, but rather should articulate our particular meaning.

Most people would perhaps define personality very much as did Professor E. A. Ross in a recent conversation. He described it as "that quality which makes people more or less unpredictable." This is the meaning in the press and in current usage. Such adjectives as "tantalizing," "elusive," "magnetic," "dynamic," "irresistible" are illustrative of the terms used to describe the individual who has a fascination or appeal because we are not too sure of his reactions.

The numerous definitions and conceptions of personality are useful for one purpose or another. But the function of the case worker is to develop personality; if the working definition of personality implies that such a change cannot be accomplished, it would be foolish for the social worker to set herself that goal. Instead of thinking of personality as more or less fixed, and character as easily changing, I prefer to think of personality as an entity capable of change and of being changed, and of character as being more or less stabilized, changing only as the integration of the dominant personalities changes.

This point of view is best defined by Professor Park: "Personality may be defined as the sum and organization of those traits which determine the rôle of the individual in the group." By traits are meant physical and temperamental characteristics, prestige, the individual's conception of his own rôle, and his social expressions and gestures. Character is organized personalities, and the process by which organization occurs may be conscious and involve emotional struggle, or more or less unconscious and involve a minimum of intellectual and emotional strain. Character is integrated only in so far as the personalities of the individual do not conflict. This last conception of personality is one that can be used in the scientific analysis of people and their behavior.

Varying Our Attitudes

It is impossible to read *Jalna* or *The Grandmothers* or *The Buddenbrooks* or Cellini's autobiography or a life of Abraham Lincoln without feeling that the various social groups known to the individuals in question had a tremendous effect upon the many personalities of each of those individuals. It is probably no exaggeration to say that an individual has as many personalities as he has groups or social contacts. Our attitudes and behavior vary tremendously with different groups. Certainly I am not the same person when I am applying for a position as when I am consulting an applicant; nor am I the same person when I am teaching as when I am being taught.

Few of us, however, organize our many personalities into an entirely consistent whole. Recently I was much impressed with the attitudes of a very plain, but extremely winning normal-school teacher of opportunity-room technique. She presumably has not been without her conflicts, but she seems to have developed a peace of mind which enables her to look calmly and objectively upon herself, the world, and its occupants. She has her opinions, but she has them calmly; she may have her

turmoils, but she does not inflict them upon her associates.

Unlike Humpty Dumpty, who after his great smash could never be put together again, it is often possible for the person himself, the physician, the social worker, the friend to reconcile attitudes and acts and to produce or to help produce a harmonious whole—an integrated character. Jane Hillyer has "reluctantly told" of her insanity and of the eventual reconciliation of her various personalities to one another. Every true friend at some time helps a disturbed friend overcome his difficulties, change his attitudes, gain his courage.

Discipline from Within

It is the main function of the social worker to assist in the development of new attitudes which in turn foster new personality manifestations and which may give the individual the impetus to reintegrate his personalities into a more healthy whole. It seems to me that a social case worker could not aspire to a nobler aim than to give maladjusted individuals an opportunity to enjoy the freedom which Professor J. K. Hart has defined as "the chance to mold your own discipline from within." Group contacts may be changed, the physical and social environment may be changed, but the case worker has not fundamentally developed the individual's personalities if she does not prevail upon him to mold his discipline from within.

At present the social worker tends to watch the overt behavior of an individual and continues or discontinues her method of approach according to the reaction. In our early contacts with a client perhaps this is the only thing we can do because we have not yet been able to analyze his many personalities. But we can proceed with our accumulation of data in such a way as to be able to understand better than we now do the many personalities of the individual and the resultant character. Not all of the individuals who seek out or who are sought out by social agencies present such problems that a detailed personality analysis is necessary.

When, however, a social worker says to herself that her main task in a given instance is to produce new attitudes, opposite behavior, a different intent, fewer conflicts, she should assume that she must make a detailed analysis of the many personalities. When such an analysis has been made, she is in a position to say what she believes to be wrong with the individual and his social environment and can then proceed to outline a program of treatment which, on the basis of her analysis and previous experience, she hopes will bring about the desired growth of personalities and resultant character.

As social workers, we expect too much. We want regenerated characters. We might very well say to ourselves that it is impossible to change the characters of many of our adult clients and remove from our ideals a program which in our reflective moments we know to be impossible. We can help to change some of the personalities of some of our clients and at times help them reintegrate their personalities into a better whole. Let us not, however, attempt the impossible.

THREE BLIND MICE

Once I was told of a small child
Who was taken to the Circus.
Distressed and bewildered
By noise, strange sights, and the whole violent confusion,
This admirable urchin burst into tears
And appealed to his Mother:—
"Mummy, sing Three Blind Mice."
Oh wise true instinct!
In the huge inscrutable uproar of the universe
Who does not sometimes turn in terror
To some old simplicity
He understands.

Christopher Morley

***Translations from the Chinese* (Saturday Evening Review)**

Public Health Nursing in Canada

THE CANADIAN NURSES' ASSOCIATION

Mabel F. Hersey, R.N.
President of the Canadian Nurses' Association

The Canadian Nurses' Association was founded in October, 1908. The present membership consists of nine provincial associations of registered nurses, eleven local graduate nurses' associations, and 29 alumnae.

The Association has three national sections: the Public Health Nursing Section, the Private Duty Nursing Section and the Nursing Education Section. General meetings are held biennially. The business of the Association is carried on through the Executive Committee composed of president, vice-presidents, honorary secretary, honorary treasurer, the chairmen of the three national sections and four councillors from each provincial association. This provides equal representation of provincial associations of nurses in the national body.

Each provincial organization has obtained an Act for the registration of nurses and has complete autonomy in regard to legislation for nurses. The national organization is the instrument by which mutual understanding and unity among organizations of nurses in Canada are promoted.

The Canadian Nurse is the official organ of the Association and has been owned and edited by the Association since 1916. The National Office was established in Winnipeg, Manitoba, in 1923 with an Executive Secretary.

Among present activities of the Association is the national enrollment of members of the Canadian Nurses' Association for emergency service in war and disaster. This is being effected through coöperation with the Canadian Red Cross Society and with consultation with the Federal Department of National Defense. A fund is being raised to aid in the study of nursing in Canada under the direction of a Joint Committee of the Canadian Medical Association, the Canadian Nurses' Association and the Hospitals' Association.

The Association is affiliated with the Canadian Council on Child Welfare, the National Council of Women of Canada, and the International Council of Nurses. Affiliation with the International Council took place in 1909.

PUBLIC HEALTH NURSING EDUCATION IN CANADIAN UNIVERSITIES

The first post-graduate course in public health nursing was established at Dalhousie University, Halifax, in 1920. The School for Graduate Nurses at McGill University offers a post-graduate course in public health nursing. The University of Montreal has established a course in public health nursing extending over one academic year. The lectures are given in French, enabling French public health nurses to be prepared for work in the province of Quebec.

The Department of Public Health Nursing at Toronto University gives an outstanding course in public health nursing. Western University, London, Ontario, offers a post-graduate course of one year in public health nursing. The University of British Columbia in Vancouver offers a five year professional course, leading to a degree in connection with the Vancouver General Hospital School of Nursing. During the fifth year a student may select a university course in public health nursing.

Province of Quebec, Lac St. Jean County Health Unit personnel

IN MANITOBA—THE GATEWAY OF THE WEST

Manitoba — the Gateway of the Canadian West — has an area of 251,832 square miles, extending north to latitude 60 and the Hudson Bay. It is a province of great lakes and rivers, rolling prairie, mountain ranges, vast forests, and rocky areas abounding in mineral wealth.

The city of Winnipeg has had well developed public health nursing services since 1902, and in 1916 the Manitoba Government inaugurated a public health nursing division in the Department of Health and Public Welfare.

Public health nursing service is supplied to municipalities on request, and is financed jointly by the municipality and the Provincial Department of Health and Public Welfare, administered directly by the Provincial Department. A nurse is assigned to a district consisting of one or more municipalities, according to the area to be covered, and the population. She is often the only nurse in the field and must of necessity give a generalized service.

The recent action of the legislature in voting an annual expenditure of approximately two million dollars for the care of the sick and the improvement of the sanitary and social conditions of the province shows that Manitoba has learned that the care of the health of the people is a public, as well as a personal, problem.

A. E. WELLS, *Assistant Director, Public Health Nursing Division, Manitoba Department of Health and Public Welfare.*

IN THE SUNSET PROVINCE

BRITISH COLUMBIA is one of the larger provinces in the Dominion of Canada, situated in the far west, on the Pacific Coast. It is extremely mountainous, being crossed by three main ranges. There are numerous small mining towns scattered all through the province, with countless rural districts in the fertile valleys. Along the coast many lumber camps and fishing villages are to be found. More than 50 per cent of the entire population of the province is centered in the two leading cities, Vancouver and Victoria. The rest of the population is scattered over a very large area where roads are only fair, means of communication usually scanty and little or no nursing and medical service are to be found.

In 1921 the Provincial Board of Health decided the time was ripe to commence developing nursing service throughout the province and the work was started with one nurse. It was immediately recognized that the work could be carried on successfully only if backed by public opinion. The branches of the Women's Institute form the largest women's organization in the province and being in the rural districts, they were the logical organization to which to present a request for coöperation. They responded enthusiastically, and a Public Health Committee has been appointed in each of the 120 Institutes. This is fast becoming a major part of their work.

The one nurse of 1921 has increased to 26 public health nurses, or public health teachers, as the Board of Health prefers to call them. In addition there are 11 nurses graduating in public health nursing this year from the University of British Columbia, who will be placed as quickly as they are ready. The present policy of the Board is to employ only those who have completed a university post-graduate course in public health nursing. The experience of these students in rural nursing is obtained at the various centers in the province, during their year at the university.

In addition to the provincial staff, the larger cities have well organized services, some in specialized, some in generalized programs. The Victorian Order of Nurses has several active branches in British Columbia.

The work of the Provincial Board of Health nurses includes all phases of a generalized program. Prenatal, delivery service, postnatal, preschool and school, as well as bedside nursing, tuberculosis, mental hygiene, all these form part of the day's work.

It is impossible for the nurses to reach all the expectant mothers in their remote mountain and valley homes. Here, the Women's Institute assists by sending to the Department the name and address of the mother. A regular series of prenatal letters, instructions regarding the layette, etc., is sent from the Board of Health, and these have been remarkably successful, judging by the letters of appreciation which have been received. A series of postnatal letters has also been prepared. It is believed that these will fill a real want in districts with a single nurse or without any, especially as a guide to the mother in the management of the child.

Dental clinics are being established in many centers. It is the aim of those in charge of these clinics to reach out to the preschool as well as the school children. The Provincial Board of Health assists any district desirous of having this work carried on, by bearing the cost of a thorough survey and examination of the children, with an estimate of the cost of the work to be done. The Board also assists the local organization in paying for indigent cases. Where the school work is included, the dentist is recognized by the Department of Education as a part of the school staff and a grant is made toward his support, just as for the teachers. It has been found that after the first or second year, the dental work becomes self-supporting even though the fees collected are kept at a minimum. The nurse plays a very important part in educating the parents up to the point where they want to have the

defects of their children remedied. It is not always possible to have the dentist go to all the outlying schools. So, early in the morning the nurse will start out with her car, collect the patients for the morning's work, leave them with the dentist and go on with her routine duties. When these are finished, back to the dentist's, pick up the children who proudly display their newly-filled teeth, and out the ten, fifteen or twenty miles to their homes.

The work is still essentially a pioneer job and as such demands a great deal of the public health nurse-teachers who are engaged in it. It has never been necessary to close a district and new centers are demanding nurses as fast as they can be trained. But the work has passed the experimental stage and is assisting in building up a vigorous, healthy people in the Sunset Province.

MARGARET E. KERR

The Hospitality Committee in Toronto is preparing a statement of all organizations which visitors at the International Council of Nurses will wish to see. This list will be distributed in Montreal at the meetings.

The attention of our readers is called to the program for the International Council of Nurses meeting, THE PUBLIC HEALTH NURSE, May, 1929, page 236.

For transportation arrangements see the March and May numbers of the magazine. For room reservations, see the May magazine. For special tours before and after the Congress, see the April and May numbers.

From the narrative report of the Lake County Nurse, Tennessee, we quote the following story:

In many respects March was an unusual month in Lake County as more than half of the county was under water and many places had to be reached by boat. Several families moved out of the water while others remained in their homes surrounded by water.

On a dark, stormy night, with lightning playing about in the heavens, a crippled man came for me to go with him to see about his brother and family. He said they were in the back water and all sick and he could not get any one to go to them. With my gum-boots on, I went with him.

We drove as far as we could, left the car, and walked a mile, then got into a little boat and rowed across the back water, finally reaching the little shack on the bank of the Mississippi River surrounded by water, with the Big River lapping under the shack. I might have gotten a bit nervous if I could have seen the channel of the Big River within three feet of us, but it was so dark we could not see anything except by flashlight and lightning.

In the only bed in the shack we found the mother who had just given birth to a fine boy; the husband, in bed with her, was unconscious. The mother said he had a "dum chill" the day before and had "knowed nothin'" since. In the shack were five other children all under nine years of age. There we were with nothing to work with, not even a towel. I had a few newspapers which I carry to be used in emergency. You can never know the real value of a newspaper until you are caught in just such a predicament as this. Using the newspapers and what few of my own clothes I could spare, I soon had the mother and baby more comfortable. I did what I could for "Pa," leaving them at 2 A.M. to try to get more done for them at daylight. As soon as we could see how to work we got clothes and food to them, later moving them out of the water. They are all living and *doing well.—Tennessee News Letter.*

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER
Board Member, Instructive Visiting Nurse Society, Washington, D. C.

INSTITUTES

A lay institute of boards of directors and committees of nursing associations was arranged in conjunction with the Mid-West Division of the American Nurses' Association at Detroit, Michigan, on April 12 and 13. Mrs. Hugo Freund, President of the Detroit Visiting Nurse Association, was chairman of the institute.

A very interesting program was planned with morning and afternoon sessions each day, an evening banquet and a joint Red Cross luncheon. A feature of the institute was the two groups of board members, one representing training schools and hospitals and the other public health nursing associations, meeting with the recognition that in spite of the different detail problems of administration there were common problems shared by both groups.

Dr. Michael Davis spoke on "Functions of Boards of Trustees and Committees." * Dr. Henry F. Vaughan, Commissioner of the Detroit Department of Health, spoke on "The Public's Responsibility for Nursing Needs of the Community." Other subjects discussed during the institute were: Finance, pensions for nurses, mixed boards, hourly nursing, publicity, problems of education. Representatives from Grand Rapids, Milwaukee, Saginaw, Sioux City, Indianapolis, Ann Arbor, Toledo and Davenport spoke on these subjects.

An interesting type of one-day institute was arranged by the Health Council of the Council of Social Agencies of Richmond, Virginia, on April 16th, with morning, afternoon and evening sessions. The boards and staffs of the agencies represented in the Council were invited to consider together "Building Public Support for Health Building Agencies."

The conference was developed by a series of round table discussions. The institute opened with a conference of the discussion leaders on procedure of conducting discussion. Round tables followed on:

The spoken word as a means of health education—Leader, Dr. Philip P. Jacobs, National Tuberculosis Association.

How to get local organizations to sponsor activities—Leader, Col. Martha Hammond of the Salvation Army.

Health projects—Dr. H. H. Hibbs, Richmond School of Social Work and Public Health.

Unusually effective printed publicity—Miss Monica Moore, Metropolitan Life Insurance Company.

Developing an interest in public health on the part of the local physician—Dr. William DeKleine, American Red Cross.

Methods of developing tax support for health activities—Dr. W. Bromly Foster, Department of Public Welfare, Richmond.

The use of dramatics in interpreting the work of health agencies—Miss Nora Spencer Hammer, Richmond Tuberculosis Association.

At the evening session the Responsibilities and Opportunities of a Board Member—and also of a Staff Member—for Interpreting the Health Needs of the Community were discussed by Mrs. G. Brown Miller, Instructive Visiting Nurse Society, Washington, D. C., and Dr. Garnett Nelson, Chairman, Richmond Health Council. Interesting discussions developed on the psychology of

* It is hoped to publish this paper in the Forum in the near future.

presenting health programs as "projects," the attitude of physicians toward preventive health work, the public control of health agencies, the possibility of health departments employing private agencies on the contract basis. The sessions were well attended throughout the day.

"Whither Public Health Nursing?" might well have been the all-inclusive title for the third annual one-day institute held in Washington, D. C., on April 16th, for the day was given over to consideration of some of the newer aspects of public health work. Delegates were invited from the Visiting Nurse Associations of York, Pa., Wilmington, Del., Baltimore, Md., and Norfolk and Richmond, Va., and in spite of torrents of rain there was an excellent attendance.

To begin with slides were shown depicting phases of the local visiting nurse work. An informal discussion was then led by Miss Huber of York, Pa., upon the current—and seemingly recurrent!—problems of local support to the National Organization, methods of selecting, eliminating and educating board members. This was followed by an extremely interesting paper on dental hygiene, given by Dr. C. T. Messner, Chief of the Dental Section of the Division of Marine Hospitals.

The afternoon session was devoted to the consideration of heart disease and mental hygiene, with particular emphasis upon the part which the public health nurse may play in preventive work.

Dr. Taliaferro Clark, Senior Surgeon of the U. S. Public Health Service, was the speaker on heart disease, outlining vividly its prevalence and some of the contributing causes. Dr. Esther Loring Richards, Associate Psychiatrist of Phipps Psychiatric Clinic, Baltimore, Md., presented a remarkably unbiased and illuminating paper on mental hygiene, bespeaking particularly a greater coöperation and understanding between the social work and health agencies in their handling of mental cases.

The Visiting Nurse Association of Hartford, Conn., members of the Hartford Community Chest, held their second annual institute on April 18th. The purpose of this year's institute was to acquaint the board members and volunteer workers with the actual routine of the nurse in the field and present method of record keeping.

A playlet on "Our Record Keeping," in which one of the assistants representing an inquirer from an out-of-town visiting nurse association asked pertinent questions about the work, began the day. The Director, Miss Harriet Leek, then gave a brief talk in which she explained the set-up of the organization's work and the type of board. She also explained the recent study of the organization which constituted a self-analysis of the past six years' work of the organization and suggestions as to how it could be made of more value to the community. Announcement was made of the visiting nurse association exhibit work which had been sent to the New England Nurses' Conference at New Haven.

A pseudo radio program was then broadcast, describing the personnel of the staff and the distribution of the work. To illustrate one of the activities of the Visiting Housekeeper, one of the children in her class of "Little Mothers" from the Union For Homework demonstrated to the rest of the class the technique of bathing baby.

The institute closed with a Health Luncheon.

The discussion of the question of "Mixed Boards," started in the May number, will be continued in July.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

INSULIN ADMINISTRATION

We publish this month policies in regard to insulin administration as adopted in public health nursing organizations with moderate sized staffs. Replies from large associations appeared in the April number.

Our association accepts all insulin patients referred by doctors. It is seldom we have an order to give insulin more than once a day. Usually there is someone in the home who can be taught to give it and the doctors are willing to have us teach this person to give the hypodermic. If the family refuses to give it, they must pay our full fee of 75c a visit, whether once or twice a day. If the family is not able to pay for our services and there is no one to give the insulin in the home, we carry that patient until the orders are discontinued. Up to the present we have not found the giving of insulin a hardship as regards time of day at which the hypodermic is ordered.—*Visiting Nurse Association, Erie, Pa.*

We have had very few insulin cases, and we carry these directly under the direction of the physicians. As a rule they state just what time they want this medicine given, generally a half hour or so before meals, and we make an effort to give it at that time. Owing to the fact that we have so few cases, we have been able to accommodate the physicians.—*Visiting Nurse League, Fort Wayne, Indiana.*

At a recent meeting of the Medical Advisory Committee it was voted to advise the Association to permit its nurses to administer insulin upon written order, or verbal order followed by written order of physician. The Committee appointed a physician to instruct nurses as to precautions and methods of administration.—*Visiting Nurse Association, Brockton, Mass.*

We have no ruling, at present, covering the giving of insulin. We have only been called upon twice for this treatment, and then only to teach the family.—*Visiting Nurse Association, Middletown, Connecticut.*

We always carry these cases through an emergency with hypodermic treatment in the home, at the same time selecting a responsible member in the home whom we can teach and who will be able to administer the hypodermic to the patient. We do not have treatments administered in the office.—*Visiting Nurses' Association, New Brunswick, N. J.*

Davenport being so near the State University, most of the patients requiring insulin that would come under our organization are sent there, and are instructed in their own care before returning home. However, when we have a case referred by a doctor we give the treatment in the home.—*Visiting Nurse Association, Davenport, Iowa.*

An article on "Nursing Typhoid Fever" in *The Canadian Nurse* advises, in addition to regular mouth care, in between feedings educate the patient (if necessary) to chew gum. This was found to be very helpful in the last epidemic of typhoid.

Chewing gum also brings relief to the patient who experiences, some days after a tonsillectomy, pain in the ears when swallowing.

In order to have nursing supplies always in readiness in the back of her car, a county nurse in Michigan bought a square tin lunch box with handles, into which she fitted a pasteboard box with a removable khaki lining. As the supplies fit in snugly they do not rattle or break. The whole outfit cost $4.50 and the nurse reports that it is very satisfactory and useful.

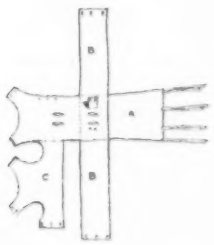
A new patent snap for holding cloth bag linings in place has been perfected by one of the well known bag supply firms. It consists of a snap like that used on old-fashioned galoshes which goes through a bound hole or slit in the canvas or linen lining and clamps down. Of course as many snaps are put on the bag as are needed to hold the lining.

Nurses accompanying patients on long journeys must often wish for some device to prevent the jerking and swaying of the head caused by the motion of the train or motor car. A head-rest or "Kosy Kush," as it is called, is an ingeniously shaped small cushion like a horse shoe which fits snugly round the neck and, resting on the shoulders, supports the head at the base of the skull. It should add to the comfort of the healthy as well as the invalid traveler. No ordinary easy chair recognizes that the head has two sides as well as a back. Wearing this head rest, one can doze blissfully, since one cannot nod.—*The Nursing Times.*

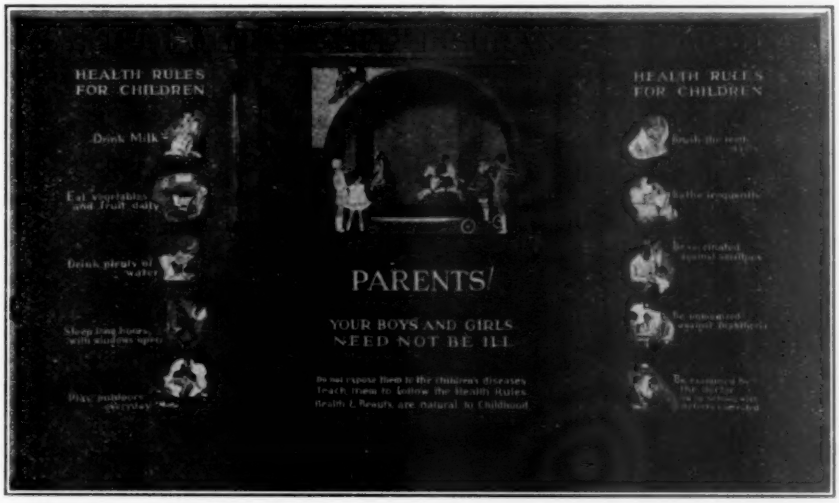
During the winter epidemic of influenza the health department of Newark, N. J., distributed a novel bib as a warning that affection unwisely displayed might easily spread the germs. On the bib was printed "I don't want to get sick. Do not kiss me. Department of Health, Newark, N. J."

A child's safety or restraint jacket has been pictured recently in the *Nursing Times* which might be useful to copy. It is quite efficient, comfortable for the child to wear, allowing him to sit up freely, and at the same time be absolutely secure. So far as possible, it is fool-proof. Another advantage it possesses is that it enables the child to be "changed" without its having to be removed, which is a great boon to a busy nurse.

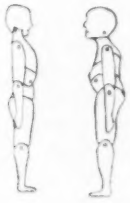
The jacket is used for children up to five years of age; it has been found particularly suitable for diphtheria and scarlet fever patients. It can be adjusted for sitting up, lying down, and alternative arrangements of pillows. The material is drill or jean, 38 in. wide, about 1½ yards are needed. The jacket (C) is buttoned over one shoulder and down one side; a strong band (B) is attached to the bottom of the back of the jacket, passed round the mattress, and tied or buttoned. Behind the child, and coming from the middle of B, is a broader band at right angles (A); this is tied to the bars at the head of the bed with tapes. When sitting up, with pillows on B, the child does not realize that it is being restrained. When lying down, a tab in B is passed through two strong slots in the back of the jacket and again buttoned into the band (see Plan of Jacket), the pillow being moved back on to A.



The joy that Peter Pan has given to several generations of children is to be carried on in a particularly felicitous way. Sir James Barrie has presented his rights in Peter, Wendy, Nana and the Pirate Crew to the Great Ormond Street Hospital for Sick Children, London. This means probably as substantial a sum as about $10,000 a year, as long as interest in the book and film lasts—many future generations we have faith to believe.



The Metropolitan Life Insurance Company has a new exhibit, a cut of which is shown, which may be loaned for fairs, meetings, etc. The exhibit will not be available until October, and any public health nurse or association wishing to borrow it must write for it at least six weeks in advance to the Welfare Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York City. The three panelled screen is 10 feet wide by 8 feet high. At least 10 feet should be allowed for depth. A direct or alternating current of electricity may be used to whirl the gay merry-go-round in the center panel, but it must be stated which current is available in sending for the exhibit. The wire for the exhibit plugs in as in any ordinary electric light socket, and the whole exhibit folds upon itself making a compact box. It weighs about 316 pounds and it would be well to ascertain the approximate shipping charge from and to New York City before engaging it.



A new posture model, known as the Dwight Posture Model, is a medium weight cardboard figure, 17 inches high, jointed at knees and elbows, at the junction of the head and neck, at the shoulder joint and to show dorsal curve and pelvic tilt. The little figure can be posed in almost any position, showing graphically good and bad posture. It will be useful for both school and preschool work. Price 75 cents postpaid, $8.00 a dozen, $50 a hundred. Order from Miss Elizabeth Dwight, 18 Browne Street, Brookline, Mass.

INGENUITY PLUS—

The Red Cross Courier tells of a rural nurse who was driving to a distant meeting when the fan belt of her car burned and "froze." Even force wouldn't move it. She had no grease nor oil in the car. In desperation she turned to her nurse's bag, and there—unguentine! She applied it with the alemite gun into the internals of the fan, and was soon on her way.

On the return trip she ran out of gasoline and had to borrow from a passing motorist. The problem of siphoning it from her rescuer's car to her own presented a problem until she thought of the stethoscope which the doctor had left on her desk after clinic and forgotten. Quickly she slipped off the two tubes, connected them with an enema point from her bag, and placing one end in the full tank, she started siphonage with her hypodermic syringe on the other end. Soon her tank had enough gas to carry on to the next filling station!

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

THE INNER WORLD OF CHILDHOOD

A STUDY IN ANALYTIC PSYCHOLOGY

By Frances G. Wickes. Introduction by Carl G. Jung.

D. Appleton & Co., New York & London, 1927. Pp. 380. Price $3.00.

This book is an adequate presentation of the viewpoint of Jung with special reference to the problems of children. It is endorsed and praised by Professor Jung in the introduction. The first six chapters present the methods of Jung's analytic psychology, together with an analysis of parental difficulties and the early relationships of the child to the evolution of personality and psychological types. The book is replete with case illustrations, which demonstrate the great clinical usefulness of the material contained in children's phantasies and dreams. It will be very valuable to parents, because of the way in which it sets forth the influence of the experiences of the parent in building up attitudes which become important factors in the developing emotional life of the child. Some of the basic motives of behavior, the need the child has for affection, compensations for inferiority and the evolution of guilt feelings are well set forth.

While recognizing these values of the book for the parent and the necessity that clinical workers have for reading it in order to get a clear picture of Jung's approach to the problems of children, at the same time it must be stated that the book is far from being "scientific in the higher sense of the word," as stated by Jung in the introduction. All of the postulates of the Jungian school are taken for granted and material which easily is interpretable on a rational and less mystical level is brought into line with these tenets. The book has a strong religious turn, uses repeatedly the mystical concept of the collective unconscious, makes free use of the concept of intuition, which is hardly a necessary concept in the understanding of most of the cases.

On the whole the book is practically useful, but it seems to the reviewer that the underlying theories must not be whole-heartedly accepted.

LAWSON G. LOWREY

MOTHER AND CHILD

ADVICE TO THE YOUNG WIFE AND MOTHER OF TO-DAY.

By Mary Lyon

A. & C. Black, Ltd., 4-6 Soho Square, London, W.1. 1928.

It is a pleasure to write of a book that is as interesting and helpful as Mrs. Mary Lyon's "Mother and Child —Advice to the Young Wife and Mother of To-day."

Every mother and father as well as every nurse could read it with profit. The book not only deals with the care of the babe, the toddler and the child, but the outstanding phases of prenatal care are emphasized thus introducing the importance of that first nine months of the baby's care and the mother's preparation for his arrival. Such common sense reasons for care are given from the beginning to the end, and short interesting excursions are taken into the results of some scientific investigations which add to the interest and charm of the book. One feels while reading it that Mrs. Lyon has profited from practice as well as theory.

As to the questions for which only theorists have definite solutions the subject matter is discussed but I note the advice lacks the final tone which the rest of the book has. Of course Mrs. Lyon has made some suggestions which might be carried out more practically in England than America—the

"pram" for instance, but generally her advice could be modified to apply anywhere. I am sorry that the book is not illustrated.

LOUISE ZABRISKIE

THE INFANT AND YOUNG CHILD

By John L. Morse, Edwin T. Wyman, Lewis W. Hill

W. B. Saunders Co., Philadelphia. Second Edition. Price $2.00.

This book, which appears in revised edition, seems to be a very suitable one for mothers, and should be of invaluable assistance in handling the many problems in the home. The information and instructions are enlightening and practical. The chapters relating to breast feeding, and the feeding of the preschool age child are well presented. There seems, however, to be a difference of opinion as regards the introduction of various foods to the breast and bottle fed babies.

The chapter on malnutrition is very well written, and brings out the causative factors—physical, social, and dietetic—and in all offers some very excellent advice. Throughout the book the authors have stressed the responsibility of the parents in the care and rearing of their children. They also point out the shortcomings of the parents as they affect the children. The mental influence in the home as it relates to the proper adjustment of the children, physically and mentally, is brought out very effectively.

CLARICE SPINDLE

A LOST COMMANDER—FLORENCE NIGHTINGALE

By Mary Raymond Shipman Andrews

Doubleday, Doran Co., New York. Pp. 299. Price $3.00.

Mrs. Andrews has given us a very interesting, appealing, and stimulating portrait of Florence Nightingale. She brings out well the driving force which helped Miss Nightingale overcome all obstacles to what she felt was her life work, and which enabled her not only to accomplish the miracle at Scutari, but all her subsequent work through nearly fifty years. One could wish fewer interpolated scenes, which as Mrs. Andrews says have no foundation in *fact*, but which she puts in to give us the spirit of history. One would wish also that Mrs. Andrews had seen Nutting and Dock, and knew how much further back our nursing history goes than the beginning of the Christian era.

And yet, withal, we are everlastingly grateful to her for this compelling, arresting, appealing, portrait, which shows how there was opened, not only the care of the sick to intelligent and trustworthy people, but a new world of freedom to women.

NINA D. GAGE

A new English textbook for public health workers has just come off the press—*Maternity and Child Welfare*, by Ethel Cassie, M.D., Ch.B., D.P.H., published by H. K. Lewis & Co., Ltd., London. The chapters on antenatal care, child management and heliotherapy, natural and artificial, will be found very practical and helpful to those who are carrying on child welfare programs.

Around the World with Hob, by Grace T. Hallock, is a porridge pamphlet for use with children in the primary grades, published by the School Health Service of the Quaker Oats Company, 80 Jackson St., Chicago, Ill. The illustrations may be colored by the children. Free copies may be ordered from the above address.

Public health nurses will welcome the revised edition of *Foods of the Foreign Born*, by Bertha M. Wood. The first edition was of great service, but this will be increased by the appendix which gives the food values of the different recipes. An index to the recipes has also been added. M. Barrows & Company, Huntington Chambers, Boston, Mass. $1.25.

The American Child, beginning with its March 1929 number, is publishing a monthly summary of child

labor bills introduced in the different state legislatures, giving the status of the bills at the time of issue.

The National Illiteracy Crusade, in coöperation with other patriotic organizations, is challenging the millions of educated sons and daughters in this nation to pay tribute to their own mothers by putting under instruction the one million illiterate women in the United States. A special book for teaching illiterate mothers has been prepared, *Mother's First Book*, into which has gone all the experience gained through the Moonlight Schools for adult illiterates which were first organized by Mrs. Cora Wilson Stewart in Kentucky in 1911.

The lessons in the book are based on mother's first interests. They are about the care of the baby, cleanliness, health, feeding the family, fresh air, exercise, cheerfulness, neighborliness and godliness. The most valuable lessons of the Red Cross on nutrition have gone into the book. The cover and the contents have been designed to give these mothers something colorful and attractive, something of their own, for the book is to be a gift. It will be sent free of charge to all those who pledge themselves to use it to liberate an illiterate mother. Copies may be secured by addressing the National Illiteracy Crusade, American Red Cross Building, Washington, D.C.

The Publications Department of the Russell Sage Foundation is issuing an invitation to social and health workers to join the *Standing Order Family*. As an individual or organization you may send your name to be placed on the Standing Order List. You will then receive every book and pamphlet issued by the Foundation. You may return any publication which falls outside your interest. Every six months a bill will be sent for the material you have kept, and a special discount of 25 per cent allowed you. The address of the Foundation is 130 East 22nd Street, New York City.

Nuts and Citrus Fruits, by Francis C. Owen and Ellen M. Ransay (F. A. Owen Publishing Company, Dansville, N. Y. Price 72 cents), is a novel and attractive supplementary reader which can be utilized to advantage in connection with school work in both industrial geography and health teaching. About equal space is devoted to nuts and to citrus fruits, and both subjects are generously illustrated. Their place in the diet is stressed.

The Metropolitan Life Insurance Company mixes a free prescription for *Health, Happiness and Long Life* in a little orange pamphlet by that name. We are particularly interested in the dose of Healthy Mental Habits. If you think in the right way, you will develop:

The habit of expecting to accomplish what you attempt.
The habit of expecting to like other people and to have them like you.
The habit of deciding quickly what you want to do, and doing it.
The habit of "sticking to it."
The habit of welcoming fearlessly, all wholesome ideas and experiences.

To remember that the patient is a person and not just a case sounds simple, but unfortunately we all forget it at times, even the best of us. A book to help us remember has been recently published by the Harvard University Press, Cambridge, Mass. (Price $2.50)—*Physician and Patient—Personal Care*, edited by L. Eugene Emerson. It is a series of lectures presented by nine doctors of note. We feel that we cannot do better than to print the titles of the lectures, and to urge every nurse in whatever field she is working to read and ponder.

Some of the Human Relations of Doctor and Patient—David L. Edsall
The Care of Patients: Its Psychological Aspects—C. F. Martin
The Medical Education of Jones; by Smith—W. S. Thayer
The Significance of Illness—Austen Fox Riggs
Some Psychologcial Observations by the Surgeon—Franklin G. Balch
Human Nature and Its Reaction to Suffering—Lawrence K. Lunt

The Care of the Aged—Alfred Worcester
The Care of the Dying—Alfred Worcester
Attention to Personality in Sex Hygiene—Alfred Worcester

A circulating toy library has been established by the Playgrounds Association of Philadelphia. The association has asked children to bring their cast-off toys to the office of the Playgrounds Association, where they will be put in packages to be sent to the municipal centers, the settlements, the day nurseries, and the hospitals of the city. Each package will remain in one place for two weeks or so, and then a different one may be taken out.

A revised folder (No. 3), *Why Drink Milk,* has been issued by the Children's Bureau. It is ideal for distributing to mothers who do not appreciate the value of milk for the family.

The School Health Service of the Quaker Oats Company has published a map project which is prepared for the fifth, sixth, and seventh grades, to be used in geography and social science classes.

It consists of three parts: a large outline map of the United States, 44 x 30 inches; a sheet of colored pictures of farm products, to be cut out and pasted in the states producing them; and a teacher's guide containing a few simple suggestions on its use.

This project may be secured free of cost for school purposes.

The map may be hung on the classroom wall or used on a large table, and there is sufficient activity involved to allow for the participation of all the members of the class.

The New York State Committee on Mental Hygiene has compiled a list of pamphlets of special interest to public health and school nurses. They are written by authorities and deal with concrete problems met by nurses. Here are some of the titles:

	Price
The Prevention of Poor Appetite in Children	$0.15
Anxiety and Fear	.15
Some Undesirable Habits and Suggestions as to Treatment	.15
How to Train Your Baby to Keep Dry	.05
Points on Child Behavior	.10

These publications and others can be secured by addressing the New York State Committee on Mental Hygiene, 105 East 22nd Street, New York City. A set of the five pamphlets above is sold for 50 cents and in quantities over 25, each pamphlet is sold at half price.

Recent publications and reprints of the East Harlem Nursing and Health Service, 354 East 116th Street, New York City, are as follows:

	Price
A Comparative Study of Generalized and Specialized Nursing and Health Services	$0.25
Lesson Outlines for Maternity Classes	.35
The Preschool Service in a General Health Program (Practical Procedure in the Home, in Medical Conferences and in Mother and Child Classes)	.55
Standards for Tuberculosis Work in a Generalized Nursing Program (reprint)	.15
Nutrition Work in a Health Program (reprint)	.10
Final Report, Section I, The Maternity Service	.25
Final Report, Section II, The Morbidity Service	.25
Final Report, Section III, The Infant Service (just out)	.25
Final Report, Section IV, The Preschool Service	.25
Mental Hygiene in a Public Health Nursing Program (reprint)	.10

Past articles on child guidance in THE PUBLIC HEALTH NURSE:

Child Guidance Clinics. R. P. Truitt. June, 1926. 320–23.
Coöperation Between Habit Clinics and Public Health Nursing Organization. Sybil Foster. April, 1928. 173–76.
Habit Training Club for Mothers ("Education—By Request"). J. Martha Kessler. December, 1928. 644.

NEWS NOTES

The death of Dr. Thomas W. Salmon on August 13, 1927, in the prime of his career, suddenly deprived the world of a personality of singular attractiveness and power, and the field of psychiatry and mental hygiene of a leader of commanding influence and usefulness. In order to keep alive the memory of such a life and the quickening influence of his spirit, announcement has been made of the establishment of the Thomas William Salmon Memorial to provide recognition to the scientist who has made the greatest contribution in the fight against mental disease during each year. Awards are to be national and international and will provide for the wider dissemination of the knowledge of mental hygiene and insanity through coöperation with the New York Academy of Medicine, in whose hands the administration of the $100,000 fund is to be placed.

A meeting of the program committee for the first International Congress on Mental Hygiene to convene in Washington, D. C., in May, 1930, was held in April in New York City.

The American Social Hygiene Association is conducting an institute at Chautauqua Institute, July 8 to August 16, at Chautauqua, New York. The courses include the following subjects:

Sex and Life
Sex and Education
Parenthood and the Character Training of Children

For further information write to the Association, 370 Seventh Avenue, New York City.

The thirtieth anniversary of the birth of the juvenile court in America occurred in April of this year, according to an announcement of the National Probation Association. The first juvenile court in America was that of Cook County, Illinois, which was established in 1899 under an act of the Illinois legislature. The bill was drafted at the request of the members of the Chicago Woman's Club and was sponsored by the Chicago Bar Association. The juvenile court movement has grown until today there are only two states without some law providing for a special court for children.

One of the minimum requirements for a successful juvenile court as listed by the National Probation Association is that the court must have the services of a clinic, with trained physicians and psychologists equipped to give mental and physical examinations to children.

The International Federation of Home and School, which is affiliated with the World Federation of Education Associations, will meet at Geneva, Switzerland, July 25 to August 4, 1929. The president, Mrs. Arthur H. Reeve of Philadelphia, has organized the program.

Miss Mildred G. Smith, R.N., staff associate of the National Society for the Prevention of Blindness, visited Arkansas in April at the invitation of the Bureau of Child Hygiene, State Board of Health. She gave demonstrations in testing vision of preschool children and lectured on the place of eye hygiene in a general health program. She worked with members of the medical society, county health units, school nurses, Junior League welfare nurses, teachers, parent-teacher associations and federated clubs.

The Public Health Section of the Tennessee State Nurses Association has appointed the following officers:

Chairman—Mrs. Bride Lee Cawthon
Secretary—Mrs. C. C. King
Educational Chairman—Miss E. Hopton
Entertainment—Mrs. Martha Bounds

A study of mental hygiene is arranged for this group through the cooperation of the teaching staff of the Medical Department, University of Tennessee, Southwestern Presbyterian University, and the City Board of Education.

The following have been elected officers of the Oregon State Organization of Public Health Nurses:

President—Mae Dwyer, Portland.
Vice-Presidents—Grace Holmes, Portland; Helen Fisher, Portland.
Secretary—Ethel Gunderson, Portland.
Treasurer—Mildred Halvorsen, Portland.
Nurse Directors—Pauline Knudson, Portland; Marion Crowe, Portland.
Lay Directors—Dr. Estella F. Warner, Salem; Mrs. Saidie Orr Dunbar, Portland.

The Michigan State Nurses' Association elected the following state officers for 1929–30:

President—Emilie Sargent, Detroit.
First Vice-President—Elsie Braun, Saginaw.
Second Vice-President—Alice Hull, Grand Rapids.
Recording Secretary—Elizabeth Robinson, Ann Arbor.
Corresponding Secretary—Amy Beers, Muskegon.
Treasurer—Emily N. Rankin, Detroit.
Counsellors—Mrs. Lystra E. Gretter, Detroit; Grace Ross, Detroit.

The new officers for the public health section are:

Chairman—Mrs. Lucile Viets, Flint.
Secretary—Miss Mildred Cardwell, Mason.

APPOINTMENTS

Eleanora Stromquist has been appointed by the State Superintendent of Public Instruction and the Director of Rural Education in Nebraska to serve on a committee in recommending a course of study in health for the elementary schools in the state.

Ada Taylor Graham as Executive Secretary of the Utah Tuberculosis Association.

Margaret Thomas as field supervisor for the Bureau of Public Health Nursing, Oregon.

Lulu P. Dilworth as Assistant in Health Education and School Nursing in the State Department of Public Instruction, Trenton, New Jersey.

Harriet F. Young as executive director of the Wilkes-Barre Visiting Nurse Association, Wilkes-Barre, Pa.

Eleanor Zuppann, superintendent of the Albany, N. Y., Guild for Public Health Nursing, was married in March to Leonard S. Waldman.

May 12 to 18 was Grading Week. All over the United States hospitals with schools of nursing joined in a nation-wide self-survey of what their schools of nursing are actually like. No other study of this kind has ever been made. It is a carefully conceived plan for a sort of educational stock taking. All of the results of this first study will be kept secret. In later years it seems probable that the names of those schools having records above the average will be published in printed lists so that prospective students and others interested in choosing a good school can know where to turn. The purpose of the first grading is twofold: It is to give to the Committee on the Grading of Nursing Schools an accurate picture, not of what the schools ought to be like, but of what they actually are like and how the schools of nursing of one locality compare with those of another. The second purpose is to make it possible for every ambitious school of nursing in this country to discover, without cost and without any penalizing publicity, exactly how it compares with other schools. The reports for the separate schools will not be published. They will be prepared individually in the office of the Grading Committee and mailed directly to the Superintendent of the Hospital, Superintendent of Nurses, and the Chairman of the Board of Trustees, and if the Superintendent of the Hospital asks the Committee to do so, a copy will also be sent to every member of the Board of Trustees.

Differences have arisen from time to time between nurses and physicians re-

NEWS NOTES—Continued

garding the scope and function of the nurse in various nursing activities. As nurses and physicians are working with the same end in view it is gratifying to learn that the Massachusetts State Nurses Association has, through its Public Health Nursing Section, formed a Committee on Relationships with the Medical Profession.

Particular problems which have arisen so far deal chiefly with public health nursing, industrial nursing, and the nurse in relation to the giving of anaesthetics. The chairman of the Nurses' Committee is Sophie C. Nelson, John Hancock Mutual Life Insurance Company.

The Michigan State Nurses' Association is offering two loan scholarships of $600.00 each to nurses resident and working in Michigan: one in the field of public health nursing, and the other in the teaching field of schools of nursing. Full information may be obtained by writing to the chairman of the committee, Miss Milenka Herc, Detroit Visiting Nurse Association, 51 Warren Ave., Detroit, Michigan.

Simmons College School of Public Health Nursing offers a course in Mental Hygiene designed to meet the needs of public health nurses and other community workers. The aim is to offer the student opportunity for becoming familiar with both the community aspect and the practical application of mental hygiene to family health work. The emphasis will be placed on prevention, but such topics as mental disease, mental defect, the psychoneuroses, and various social problems in which mental factors play an important part will be discussed. For further information write to Miss Marion M. Rice, Director, School of Public Health Nursing, 300 The Fenway, Boston, Massachusetts.